ILCOR
International Liaison Committee on Resuscitation
Minutes of the 11th Meeting held in Orlando, Florida
May 27, 1998

1. Present:

1.1	ERC	Petter Steen Leo Bossaert Anthony Handley Colin Robertson Francisco (Paco) de Latorre Svein Arne Hapnes Douglas Chamberlain
1.2	AHA	Richard Cummins Mary Fran Hazinski Vinay Nadkarni Bill Montgomery Karl Kern Lance Becker Tom Aufderheide John Kattwinkel (AAP)
1.3	HSFC	Brian Connolly Martin Osmond Marc Gay
1.4	RCSA	Walter Kloeck
1.5	ARC	Vic Callahan Jim Tibballs Pip Mason (New Zealand)
1.6	CLAR	Raul Alasino Sergio Timerman Carlos Reyes Elinor Wilson
1.7	IAHF	Elinor Wilson
1.8	Staff	Ted Borek (AHA) Molly Pond (AHA) Jerry Potts (AHA) Mary Elizabeth Harriman (HSFC)

2. Excused

2.1 Alan Erasmus (RCSA)
Efraim Kramer (RCSA)
David Zideman (ERC)

Barbara Phillips (ERC)

3. Meeting Called to Order by Petter Steen and Richard Cummins at 8:40 am.

3.1 Introductions were made around the table by all. A brief history of ILCOR was provided by Richard Cummins, Douglas Chamberlain and Bill Montgomery.

3.2 ILCOR began in 1992 at the 1992 AHA Conference on Guidelines for CPR and ECC. A proposal was put forward to the AHA, ERC, ARC, HSFC, RCSA, NZRC representatives to form a liaison committee on resuscitation guidelines. The major purpose was to identify and review the world's science bearing on resuscitation and emergency cardiovascular care.

3.3 Since 1992 nine subsequent ILCOR Meetings have taken place. These meeting focused first on identification of areas where guidelines differed from national to nation. Then ILCOR engaged in a consensus-based discussion of these differences, in an effort to identify common grounds, common science, and a consensus conclusion regarding the guidelines.

3.4 The consensus conclusions and recommendations, termed "Advisory Statements" were endorsed by the respective resuscitation councils, not as "standards" but as "advisory statements". These were published in the Spring of 1997 in *Resuscitation, Circulation, and Trauma and Emergency Medicine.*

4. Reception and Effect of ILCOR Advisory Statement for individual resuscitation councils:

Drs. Steen, Cummins, and Chamberlain led a discussion of the reception and effect of the Spring, 1997 publication of the ILCOR Advisory Statements.

4.1 **UKRC** – Chamberlain, Robertson. The United Kingdom Resuscitation Councils tested out the ILCOR Advisory statements for the ERC as the recommended guidelines to be followed by all resuscitation training groups in the UK in 1997 – 98. These guidelines were presented to the UKRC and others at the Resuscitation Congress, in Brighton, England in May, 1997.

4.2 **ERC** – Leo. Most ERC members have followed the guidelines published. ILCOR Advisory Statements have served as a base for the development of ERC 1998 guidelines. These will be released at the Resuscitation '98 Congress in Copenhagen, Jun 5-6, 1998. The ERC Guidelines incorporate most of the recommendations from ILCOR Advisory Statements, as does the UK (Colin Robertson). UKRC – Tony Handley: BLS guidelines pilot tested. Need some minor revisions. New recovery position is difficult.

4.3 **AHA** – Richard/Tom/Mary Fran – the pulse check is difficult for people – not very accurate. Need data on this. May develop some data in Norway. Lance Becker –advisory statements have had a direct impact where people use them. In the US, not a large direct impact with the main AHA Subcommittees, simply because this is not the time when the AHA focuses intently on the details of the guidelines. Important from the AHA perspective is that ILCOR Advisory statements have raised the issue on the recovery position and other technical areas. This topic

has spread through the BLS Sub-Committee with a much greater awareness that these topics remain unresolved. Vinay Nadkarni and Karl Kern: guidelines have helped for it is valuable to see what is being done in other locations.

4.4 **AAP (American Academy of Pediatrics).** John Kattwinkel reports that AAP plans to use neonatal guidelines and incorporate them as they appear in the Guidelines 2000. Numerous statements of praise and appreciation were extended to John, Vinay, Barbara Phillips, David Zideman, and Jim Tibbals for working on the neonatal, and newly born algorithms in a successful collaboration among the organizations. Conclusions will be presented at pediatric breakout. Vinay – pediatrics want to make a very global-general document. For unknown reasons, WHO has recently published New Born guidelines without involving ILCOR or referring to the ILCOR Advisory Statements. This occurred even though a major WHO officer has attended and participated in more than 3 meetings.

4.5 **CLAR** – Carlos Reyes – ILCOR has had a tremendous impact on the materials in Latin America. Positive response to international guidelines. Material clear and simple. Worried about quality control for BLS training and performance. Plan to strengthen BLS. Carlos feels the need to prepare their own materials so that it matches specific local conditions. However, ACLS is different – more universal. Elinor Wilson reports that IAHF is trying to bring together common materials since there are so many different versions of texts. Working with the AHA on materials. The goal is to have every country represented on the ECC Committee. Carlos feels that for BLS every country needs to do their own materials.

4.6 **HSFC** – ILCOR is being widely used. Mary Elizabeth Harriman – has national guidelines in 10 provinces. BLS materials in English and French. Canada does think differently – materials are more concise.

4.7 **AUSTRALIA** – changes their statements frequently; not bothered by the differences between the AHA and the ERC. They are compatible with ILCOR. Well received. Pip – Getting a formal response on ILCOR, particularly with BLS. Teaching point of view – problem is there is no breathing – need to clearly state what is recommended. Mouth to nose resuscitation is an issue that needs more research. Topic now dominated by one research group. Good response to the universal ALS algorithm. Will be publishing their own guidelines. PEDS is very well accepted. Guidelines for newly born are needed and timely.

4.8 **RCSA** – Walter Kloeck – Southern Africa Resuscitation Councils have published ILCOR Advisory Statements in **Trauma and Emergency Medicine** in a guidelines issue in October, 1997. All training is based on ILCOR guidelines. Adopted ILCOR guidelines. Materials come from all over the place. BLS is adopted completely. Would like guidelines for 2 person CPR. Concept of choking is common and a severe problem in South Africa. The incidence is not as low as indicated in guidelines. Prefers one algorithm for all; infant, child and adult. ALS is accepted but would like dosing mentioned. Whatever current recommendations are.

5. Guidelines Development Process: reviewed by Richard Cummins.

5.1 **Evidence-based guideline development.** Richard Cummins and Lance Becker described the rapid changes in the AHA process for developing resuscitation guidelines. AHA has moved dramatically from the former use of expert opinion and consensus discussions, to a much more explicit, evidence-based process. This process was described in an article that appeared in CIRCULATION,, April 28, 1998 where "Biphasic Waveform Defibrillators" were reviewed as the first example of this process. Dr. Lance Becker presented another example of evidence-based guideline review using the example of best volume recommendation to make for CPR ventilations.

- refine clearly the guideline question (done by the entire subcommittee or working group)
- systematically review the medical literature for all the "standard articles" on topic (use at least 2 reviewers to ensure identification and review of all relevant scientific articles, from around the world. Some people who have tried this admit to the tremendous time and energy this step requires.
- Develop selection criteria for acceptable and unacceptable articles
- Grade the "power" of the evidence-articles by grading them on a scale based on study design and study methodology (termed "levels of evidence" by the AHA).
- Assess the published articles for whether the study design was executed well, was powerful and was persuasive.
- 2 or more expert reviewers summarize their review, concentrating on how close the science comes to answering the specific question of concern.
- Reviewers propose, based on their review, a preliminary "class of recommendation" for an intervention. This class of recommendation will be discussed and debated in the Subcommittees and working groups.

6. Discussion of ILCOR Guidelines Development Process and future involvement with AHA process: separate or integrated?

6.1 This process, as described by Drs. Cummins and Becker, is costly in terms of time, energy and personnel; but offers a unique opportunity to truly perform evidence-based guideline review and development. The AHA is extremely interested in having topic experts from ILCOR join the AHA in this process, working to be ready to produce, in January, 2000, the worlds' pre-eminent resuscitation guidelines as a truly "international" set of guidelines.

- While much work has already occurred the AHA acknowledged how important it is to have other Resuscitation Councils join the AHA in this effort. This collaboration would possibly allow the use of the term "international" for the guidelines, though a number of ILCOR members were uncomfortable with the use of "international " for a process that was supported mostly by the AHA.
- The AHA extended an unconditional invitation to have ILCOR join in this process as equal partners, and to seek a level of involvement that was exactly equivalent to that which AHA volunteers and experts exercised.
- The AHA representatives acknowledged the lack of full coordination in guideline development process, and publication dates.

- Due to the amount and cost of work involved the AHA pointed out that its members would not be able to participate in a separate, ILCOR-based guideline development process. AHA restated its high level of openness and desire to have ILCOR and all other resuscitation councils involved as contributors. It was pointed out that there were many advantages in international collaboration to save time, money and duplication of efforts.

Douglas Chamberlain – Observed that a coordination problem arose when AHA arrived at an unexpected date for new AHA guidelines; rather than a1998 the AHA changed to the year 2000. The AHA pointed out the phenomenon of "exhaustion of susceptibles" had occurred in the AHA. The few members who survived the 1992-94 process were unable to recover fast enough to meet anything other than a 2000 deadline. Dr. Chamberlain noted that all international groups need to maintain their autonomy. How should ILCOR interact with AHA? AHA produces science-based guidelines to produce training materials. Should consider testing with Pediatrics since they are well on their way.

6.2 **Lance Becker** – we need to get beyond guidelines and talk about money. How we can develop joint materials and benefit all parties involved. Sven Hapnes – proposed global guidelines – training – and the sharing of results.

Ted Borek – AHA invited ILCOR to be a part of the guideline development 2000. By incorporating ILCOR / international expertise, the entire group will benefit by having worldwide guidelines. AHA would hold the copyright, but this appeared to be an area of semantic differences. To many people "copyright" seemed to mean control and restriction and royalty costs. Ted Borek pointed out that copyright ownership simply meant which organization would assume responsibility for "policing" our combined publications, and preventing other, non-ILCOR using the materials in an unauthorized manner. Copyright can easily be transferred over to individual resuscitation councils for use in specific geographic areas.

Mr. Borek proposed that for the year 2000 experts from all over the world join forces in the guideline development in conjunction with the AHA guideline development. All international resuscitation groups would have input into international resuscitation guidelines. They would then be published in Circulation and Resuscitation, Trauma and Emergency Medicine, and possibly other appropriate journals. Williams and Wilkins would then distribute the guidelines throughout the world. The local resuscitation council would benefit financially from the sale of the guidelines in tier country. In addition, a small portion would be allocated to ILCOR. There would then be opportunities to develop texts and translations if parties are interested providing an additional financial incentive back to the local resuscitation group.

7. **Current Plan for international guideline development for the year 2000.**

7.1 After much discussion the group agreed to move forward to develop international guidelines (name to be determined) in conjunction with the process of AHA's for the year 2000 as outlined below.

7.2 All ILCOR member organizations agree to participate in the AHA process towards 2000. ERC should send 7, CHLF 3, RCSA 3, ARC/NZRC 3, and CLAR 3 participants to the AHA meetings in Dallas. The meeting schedule is as follows:

Dallas, Oct 6 – 9, 1998
Dallas, March 23 – 26, 1999
Dallas, Sept 25 – 29, 1999 ((evidence/review)
Dallas, Feb 5 – 9, 2000 (guideline 2000 conference)

For the October meeting all should plan to arrive on Oct 5th and plan to meet on Tuesday, October 6th and Wednesday, October 7th. Individuals should plan to leave the evening of October 7th or early on the 8th if flights are not available. AHA will cover the costs associated with this meeting for flight, hotel, meals and transportation under the general AHA travel policy guidelines (see attached expense report with policy on back).

7.3 The major work in the science based guidelines process will occur between these meetings in small task groups that prepare the scientific evidence for answering the questions raised. The delegates from the non-AHA organizations in the different working groups (ACLS, BLS, PEDS) will cooperate directly with the chairperson of the AHA working groups in suggesting/designating non-AHA members to these task groups.

7.4 In accordance with previous ILCOR experiences, it is important to emphasize continuity in picking out delegates to the Dallas meetings. This should be combined with a position of influence in home organization. Each organization should report as soon as possible to the AHA (Molly Pond) who the delegates will be. As many of the non-AHA members of the task groups will not be present at the Dallas meetings, the delegates must be ready to discuss the scientific evidence brought forward by such non-present task group members.

7.5 The guidelines (name to be decided later) will be published in Circulation and Resuscitation, and thereafter as a book throughout the world by William's and Wilkins. The profit from the book sales in the different part of the world will be given to the ILCOR member organization covering that part of the world. A portion of the profit will go to ILCOR (suggested 1%). or other distr.

7.6 There will be opportunities to develop texts and translations if parties are interested in providing an additional financial incentive back to the local resuscitation group.

7.7 Some other topics of collaboration that were briefly discussed:

- Common illustrations
- Basic education principles
- Offer reciprocity worldwide
- ILCOR responsible for science guidelines consistent throughout the world
- 2000 guideline development

8.0 Adjournment. The meeting was adjourned for the break out of sub-groups at

4:15 PM.
Sub-group reports are attached to these minutes. (ACLS, PEDS and BLS)

Respectfully submitted,

Petter Steen and Richard O. Cummins
with the support and assistance of Molly Pond