ILCOR
International Liaison Committee on Resuscitation
Minutes of the 12th Meeting held in Dallas, Texas
Thursday, March 25, 1999

1. Present:

1.1	ERC	Petter Steen Leo Bossaert Anthony Handley Barbara Phillips Francisco (Paco) de LaTorre Colin Robertson David Zideman
1.2	AHA	Richard Cummins Mary Fran Hazinski Vinay Nadkarni Bill Montgomery Karl Kern Lance Becker Ahamed Idris
1.3	HSFC	Michael Shuster Martin Osmond Marc Gay
1.4	RCSA	Walter Kloeck Alan Erasmus
1.5	ARC	Peter Morley Ian Jacobs (substituting for Jim Tibballs) Pip Mason (New Zealand)
1.6	CLAR	Raúl Alasino Carlos Reyes Saúl Drajer (substituting for Sergio Timerman)
1.7	Staff	Ted Borek (AHA) Molly Pond (AHA) Wes Clark (HSFC) Larry Kronick (AHA)
1.8	Other Observers	Matthew Ma (Taiwan) Sant Chaiyodsilp (Thailand) Yi-Tang Wang (China)

2. Meeting called to order at 6:50 PM by Petter Steen. Introductions were made around the table.

3. Review of meeting minutes. Mission statement added in as it was not included – comment from Petter. This amendment was already included in the minutes. Minutes were approved.

4. Membership body representing South/Latin America. Saúl Drajer and Carlos Reyes presented that CLAR will be the scientific arm of the IAHF. They will operate under one umbrella. Attachment outlining details of the agreement.

5. Feedback on Guidelines Development Process. Richard reviewed the process of which the guidelines are being developed and provided a historical perspective.

   1992-1999
   - Utstein out of Hospital Cardiac Arrest, Circulation, Resuscitation, AEM
   - Utstein Pediatrics , Circulation, Resuscitation, AEM
   - Utstein in Hospital, Circulation, Resuscitation, AEM
   - Utstein, laboratory CPR research, Circulation, Resuscitation, AEM
   - ILCOR Advisory Statements, Circulation, Resuscitation, AEM
   - ILCOR Newly Born, Circulation, Resuscitation

   ILCOR Advisory Statements were an excellent collaboration of international expertise. The AHA then realized they needed to get going on the AHA newly revised guidelines. There was then a decision made to collaborate with the international expertise to develop the AHA international guidelines 2000. It will be presented how the new guidelines will reflect the international representation and participation. There can be differences that will exist culturally and based on available resources in individual countries and/or continents.

Comments: Add in Newly Born – David Zideman (done). Brazil and South Africa have published the ILCOR guidelines. Used in Chile and South America for guidelines. Petter asks that people turn in what is published to him of the ILCOR guidelines so he is aware of what is happening.

Feedback on guideline development.

Peter Morley – discovered that class of recommendation is sometimes independent of the class of evidence.
Walter Kloeck – there are issues that will not work in South Africa – i.e. Call 911, does not work in SA. Video based training can allow for local content.
Pip Mason – has enjoyed the process of the past two days. At first it was confusing but now seems very clear.
Ian Jacobs – systematic reviews are a large task. Some of the process is new. The data on some issues is miniscule – lack of evidence. This is the next issue that we face to coordinate and integrate internationally.
What topics are not being captured internationally (Richard).?
Special situations - (Leo) ILCOR statement was too brief on this issue
Richard mentioned that ACLS is too big and is being broken out into two courses, regular and advanced.
Peter Morley - Drugs – some are not available in every country.

Lignocaine vs. lidocaine, dosages
Why have all us wise men not improved survival rates in 30 years? Why do we have such a cumbersome process? We have the opportunity to improve this. (Colin) A cumbersome process will concentrate on a very small minutia that does not impact the overall survival rate(Colin). Richard disputes this and says with transportation, AED, etc. there is an increased survival rate. We can't lose sight of the basic process. A lot of data exists, Richard disagrees with Colin and it is a big topic to cover at this meeting. We are all trying to solve a problem that isn't easy to solve.
David Zideman – is privileged to be a part of the group. PEDS is a good model for how things can work. He agrees with Colin's comments. The PEDS materials were very similar to ILCOR / ERC. He saw some power plays going on in some of the meetings. It was subjective. Moderators are going to need to control this and keep it more objective. PEDS appears to be swallowed up into the adult content. Needs to be separate.
Barbara Phillips – feels very stimulated about the diversity of the participation and going back to her country. We have not looked at all at retention of skills of training and effective teaching. ERC can contribute to this and hopes it is better developed in September.
Paco – very grateful for participating. Hard work, not an easy task! The evidence level will help gain consensus with the science and the way it is gathered. It is important to put the guidelines together in such a way that it is easy to teach.
Richard mentioned that it can really vary depending on who the audience is for the training. The guidelines are developed primarily for the healthcare provider. We are trying to get the most effective format for the material.
Tony – We need to look into the future of ILCOR as a means by which we can continue to look into the process of improving the guidelines. We are only scratching the surface. There is inadequate process for the areas where there is no level of evidence or science. The system by which this is being done is good but could be tightened up a bit. The proposals heard seem to be arbitrary – picked out of the sky, with no feeling of ownership. Not certain why proposals are being picked up. Reiterates what Barbara says – need to validate teaching.
Richard indicates that need to get grant applications to AHA in the area of resuscitation. Less than 1% are currently funded in this area.
Leo – Process was exciting although it took time to figure out the process. Very helpful two days. Amazed by the enormous amount of work that has been put into this process. Is not clear on how the evidence will turn into recommendations and guidelines but will wait and see how it goes. It will be important to figure out how to translate the guidelines into training materials. That will be the responsibility of each continent.
Martin Osmond – Like David he feels that being part of PEDS that he has been able to have good input into the process. Only concerns are how to take levels of evidence and turn it into a class of recommendation.
Michael Shuster – evolution of evidence review has really improved. In 1992 there were discussions of not making the guidelines so infrequently. Perhaps we can find a way to make this an ongoing process rather than waiting another five years to do it again. Needs to simplify training. Great that AHA is doing that with ACLS.
Marc Gay – A good balance between AHA and international representation. BLS process is going very well and participation is essential and valuable. Agrees with Tony that certain topics and issues have no evidence and we are trying to fit this into the process when it needs a separate process to deal with it. Concern is that the process is being pushed very fast. Trying to do this is hard. Should prioritize the topics considering the time available.
Carlos Reyes (on behalf of IAHF/CLAR)– It is a great opportunity to be here and participate. Seems to be some competition between ILCOR and the guideline development. Not all countries are represented and should be. In Chile the mortality is very high but things are improving and will continue to do so. More training is necessary in Chile with the lay providers.

Many countries will use these materials. Being a part of this process they understand why we do what we do.
Ahamed – spent 6 months looking at the literature and has a good understanding of why we have undertaken this process we are doing today.
Petter Steen – has done one project and has found it a very useful exercise. He has come to realize that scientific based guidelines are useful but that the decision making process can still be very irrational.
Matthew Ma – will challenge his colleagues to create more science to bring back.

6. Richard introduces Ted Borek as the Vice-President of ECC. He has been on board for over two years and has made a tremendous impact on the program.

Ted covers what we hope to accomplish by the year 2000. First aspect relates to why we are all here. In 1992 guidelines were issued and printed in JAMA. The big change is that we will not publish the guidelines in JAMA but will be in Circulation, Resuscitation and other countries' resuscitation journals. The guidelines will be a stand alone product offered to individuals, institutions or anyone around the world who wants to purchase guidelines. The next stage brings us to two different types of guidelines. The concept is to bring across the image that these are international guidelines. In the USA we will publish the guidelines with the AHA Heart and Torch. For outside of the USA we will develop an international version of the guidelines sold outside of the USA without the AHA Heart and Torch but will list all the resuscitation councils that participated in the development of the international guidelines. We will address many of the subjects that have gone around this evening that are unique to international such as 911. We will look at the international guidelines becoming culturally neutral at least from the science standpoint.
Tony – will the text be the same for USA as is for international? There will be changes made to be more appropriate internationally . These would be available through the four distributors and others that may be identified so they are readily accessible. The revenue sharing is based on the amount of materials sold in each country so that the funds go back to the local resuscitation council.
Leo says it will work as long as everyone agrees with the final product. Richard says that we are building in a process where the issues that need addressing will not be overlooked for the international version. Resuscitation councils would not be distributors but promoters of the guidelines.
The next piece is the proceedings. If someone wants to purchase the reports that were used in how the guidelines came about they can do so. They will have a similar cover. People would purchase this if they want to know how the guidelines were derived. This will be published in Annals of Emergency Medicine and other resuscitation publications. For sake of clarity we will have two different covers.
Last issue relates back to the topics regarding training and training materials. AHA will work in conjunction with the guideline development on the texts. They will begin to be available at the end of the year 2000. AHA is open to discussing with any resuscitation council sharing the texts and revenue from the texts. Joint logos can also be on these materials. Please share feedback on covers or texts with AHA volunteers or staff.
Petter states that they may very well take the science and create their own training materials rather than using the AHA materials. It will be the decision of the local resuscitation councils. We would gather some research on the different ways of teaching from one country to the next.
Ian Jacobs – clarifying that they can choose to use or not to use the AHA materials? If resuscitation council wants to do their own thing they can and AHA will do their own production and distribution. This can present a problem when resuscitation councils do not create training products but work cooperatively with other agents to deliver training materials. (Ian)

Pip says our materials will be in conflict with what they are developing in New Zealand since they have created a seamless process with all levels under one umbrella. This is like a book store mentality.

The AHA's position internationally has been that they will respond to requests from individual countries by suggesting first that they contact their local heart foundation and / or resuscitation council. If their needs are not met AHA is willing to work with them to do so. An example is given as to how the ERC receives requests from Molly Pond and if they cannot meet their needs AHA will help them.

7. Proposal from Australia/New Zealand. Delegates for AHA and ERC should be 6. How can other resuscitation councils join ILCOR? This needs to be added in. To be eligible for ILCOR there is an existing resuscitation council representing more than one country and they have responsibilities for training and teaching of resuscitation. It is proposed that the definition be mapped out and proposed for the next meeting. This will be conducted by New Zealand.
   Petter suggests that we leave the mission statement as is. Approved.
   Defer the executive committee until we have a better idea of what we are going to do.
   Approved Australia/New Zealand (Australian secretariat) takes over the administrative responsibilities until the year 2002. No need to have a membership fee. Approved

An idea was suggested that the secretariat of ILCOR solicit top five issues that need to be addressed as ILCOR.

8. Future Meetings? Petter says that this works a lot better having these meetings at the end of the science development. Mary Fran proposes that we have a social event the last night of the meeting. Rather than doing this the group decided that there be no ILCOR meeting until May, 2000. This would be held on May 31, 2000 in Antwerp.

9. Other Business. Vinay said that in the past ILCOR wanted to create a repository of all resuscitation council guidelines. All guidelines should be forwarded to the Australian Secretariat and they will house this information. Leo asked about the proposal for the publication of 2000 that all the logos of the participating organizations be published on the inside of the cover. This was agreed upon.

10. Meeting was adjourned at 9:45 PM.