Invitation for ISCCM Day Poster Competition

Dear ISCCM members,

Greetings from ISCCM office.

We have been celebrating ISCCM Day every year with a theme. The theme of ISCCM Day for this year is "Patient Safety in the ICU"

Poster display is a good method for making doctors and lay people aware of Patient safety in the ICU. Taking the opportunity of the ISCCM day celebration, we are announcing a Poster competition on "Patient Safety in the ICU"

Top 2 posters will receive a citation from society and prize of Rs.10,000 and Rs.7,500 respectively.

Instructions for submission of poster on "Patient Safety in the ICU"

1. Ensure that poster is catered to the Indian Setup.
2. It should be original and not copied from somewhere else.
3. Should be in poster format.
4. Words allowed - up to 100 maximum.
5. Should be in English.

Last day for submission is 10th September 2016 and it should be emailed to Dr. Vijaya Patil, Secretary ISCCM and Chairman, ISCCM Day Committee, ISCCM at vijayappatil@yahoo.com

We welcome any other suggestion from our members.

With warm regards,

Dr. Kapil Zirpe
President-Elect, ISCCM

Dr. Vijaya Patil
Secretary, ISCCM & Chairman, ISCCM Day Committee

Dr. Pradip Kumar Bhattacharya
General Secretary, ISCCM

Dr. Atul Kulkarni
President, ISCCM
Dear Colleagues,

GREETINGS! It has been my great pleasure working with my team. Since I took over as the Editor-in-Chief in March 2016, we have successfully made the smooth transition, thanks to everyone who have helped me during this process. This July, we had a wonderful Best of Brussels meeting. I wish to express sincere thanks as an organizing secretory, to all of you for attending "Best of Brussels” symposium at Pune, India.

The ELICIT Task Force was held at the town hall meeting in Delhi, on the 10th of July 2016, with participation from intensive care specialists, neurologists, palliative care specialists, lawyers, laypersons and many others. The meeting was held as a series of panel discussions. We must appreciate continuous efforts of ISCCM team involved in this task. Please find detail report on page….THIS YEAR, Elections for election of members to the Executive council for 2017-18 has been smooth affair. Since last year, a few key changes have been made in the election process to facilitate ease of voting and to increase the member voter base. We as an Intensive Care Community in India have to realize our potential in contributing towards Brain Death Donors often called as ‘Cadaveric Organ Donation Program’. There is huge MISMATCH in demand & availability of organs. Let everyone of us start taking a lead in organ donation process, identify patients and then successfully declare a patient brain death.

This year theme of ISCCM day is "Patients Safety in ICU ". I appeal everyone to celebrate our ISCCM day at their respective places with awareness programs. ISCCM is preparing slide kit & program material which will be distributed to your city branch office soon. Also request all of you to encourage your nursing staff as well juniors in participating in the Poster competition for ISCCM day.

Last but not least please share your valuable opinions or do send glimpses of your local activities to us.

Dr. Kapil Zirpe
Editor in Chief,
The Critical Care Communications
President-Elect, ISCCM
kapilzirpe@gmail.com

www.isccm.org
Dear ISCCM members,

Greetings from Mumbai! Hope you are enjoying the vigorous monsoon very much. As expected we had a wonderful Best of Brussels meeting. The workshops preceding the conference were of the highest quality which we have come to expect from the Pune branch. The Lavani (a Marathi dance style) program in the evening was very entertaining. During the conference we had a meeting with Dr Daniel De Backer and Dr Massimo Antonelli, current President and President Elect of the European Society of Intensive Care Medicine. We have come to an agreement on many points and I will be shortly signing the agreement of behalf of ISCCM with European Society of Intensive Care Medicine. We are hoping to start a fellowship program in European centers so that our members can go and do an observership there and if possible actually work in European ICUs.

I recently attended the second conference of Association of South Asian Region Critical Care Societies in Colombo. We are in the process of finalizing the constitution of this organization. The aim of the association is to exchange knowledge, carry out collaborative research across the countries in our region (since we have similar health problems across SAARC countries) and enthuse young minds to take up critical care and educate them as per the latest evidence and educate them as per the latest evidence in the field of critical care medicine. The third conference of Association of South Asian Region Critical Care Societies will be held at Varanasi along with our National Conference of ISCCM. In Varanasi, Dr Kapil Zipre who is will take over from me as ASARCCS president, currently he being the president elect.

Please tryout the ISCCM app, Download it from Google playstore and give us your feedback. Last but not the least, the preparation for Criticare 2017 is well underway. We expect to finalize the scientific program for Criticare 2017 by the end of this month.

By the time you get the newsletter the results for the members of the national executive committee elections will be decided. Unfortunately many members will have been prevented from voting because their electronic contact details (mobile nos. and e-mail addresses) were not updated. I once again urge the members to update these details by filling the update form available on the website. The festive season is coming up. I wish all of you a happy and prosperous year ahead. See you in Cochin!

Dr. Atul P. Kulkarni
President, ISCCM
kaivalyaak@yahoo.co.in

New Office Bearers of ISCCM Branches

**Surat**
- **CHAIRMAN**
  - Dr. Yogesh Desai

- **SECRETARY**
  - Dr. Samir Gami

- **TREASURER**
  - Dr. Ronak Nagoria

**Kolkata**
- **CHAIRMAN**
  - Dr. Ajoy Sarkar

- **SECRETARY**
  - Dr. Souren Panja

- **TREASURER**
  - Dr. Rajarshi Roy

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Conference on Critical Care Medicine & Pre-Conference Workshops

24th - 27th November 2016 • Hotel Centre Point, Nagpur

Organised by Society of Critical Care Medicine, Nagpur.

**MMC CREDIT POINTS APPLIED**

- Infectious Diseases (CAI & HAI)
- Obstetric Critical Care
- Sepsis & Shock
- Endocrine emergencies

- Plenary sessions, Mahacriticon Orations, How do I do it?
- Thematic Sessions, Debates & Quiz
- Case base learning from the members

Hands on Workshops useful for every Intensivist

ACLS • Mechanical Ventilation • BASIC • Hemodynamic Monitoring • Critical Care Nursing

FOR REGISTRATION PLEASE CONTACT

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Opp. Somalwar High School, Ramdaspeth, Nagpur - 440 010. 9823083037 • rbarokar2010@gmail.com

mahacriticon2016@gmail.com

For Online Registration visit our Website

www.isccmnagpur.com
Dear Members

We are near midway of this term year. I always fear that time is moving very fast and too many things are to be done. But rightly said by Earl Nightingale “Don’t let the fear of the time it will take to accomplish something stand in the way of your doing it. The time will pass anyway; we might just as well put that passing time to the best possible use”. ISCCM is working very hard to improve in the field of academics, educations and research and some of the examples which happened recently are;

We launched CCIDC Course with a huge success, we made a new guideline for conducting good workshops at National Level, We signed a successful MOU with ESICM to promote our educational and academic activities, We have contributed to a large extent in the India’s Draft Bill on Passive Euthanasia with “End Of Life

Car issues” and many others. ISCCM App has been launched with great success and it will solve many purposes of ISCCM in future. CHITRA Study is in full swing and more than 2000 patients have been enrolled by now. Many new hospitals have joined with our ISCCM Course, To promote the Nursing Course a revised registration charges has been implemented so that more nursing students can join and take the advantage of the course, Very soon new guidelines are also going to come up. Preparation for ISCCM day celebrations are in full swing, and I request students to prepare and send their posters at the earliest. Elections have started and I request all the members of ISCCM to contribute with their valuable votes so that a strong Central Body with good future commitments can be formed.

With All Good Wishes

Dr. Pradip Kumar Bhattacharya
General Secretary, ISCCM

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Quiz Third Edition

1. Spot on

2. Expansion of DEBONEL

3. 32 year old female is admitted to ICU after cardio-pulmonary collapse secondary to Hanta Virus infection. What is the treatment of Hanta Virus Cardio-Pulmonary syndrome (HCPS)?

4. This year in history

When was Penicillin invented?

5. In trauma care the acronym MIST stands for:

FDA approved indications: cUTI & cIAI
(complicated urinary tract infection and complicated intra abdominal infection)

4. Term used in aviation industry to replete oxygen reserves by jumping from seat to seat. Oxygen from mask is deeply inhaled.

5. 1 gram / kg

6. 2011

7. Appropriate immediate management at this time is to:

8. What is common to these drugs Trastuzumab, Doxorubicin,Paclitaxel & Cisplatin

9. Who Am I? – Identify the device

10. Frictional NJ tube
Features innovative flaps or barbs which allow peristalsis to gently drag the catheter into the jejunum

Answers to Second Episode

1. Trypsinogen is proposed serum biomarker for Acute Pancreatitis

2. DAMP expansion

3. 32 year old female is admitted to ICU after cardio-pulmonary collapse secondary to Hanta Virus infection. What is the treatment of Hanta Virus Cardio-Pulmonary syndrome (HCPS)?

4. This year in history

When was Penicillin invented?

5. In trauma care the acronym MIST stands for:

FDA approved indications: cUTI & cIAI
(complicated urinary tract infection and complicated intra abdominal infection)

4. Term used in aviation industry to replete oxygen reserves by jumping from seat to seat. Oxygen from mask is deeply inhaled.

5. 1 gram / kg

6. 2011

7. Customized, Health in Intensive care, Trainable Research & Analysis Tool (CHITRA)

8. Swan Ganz

9. No cover piece placed over floor cleaner.

10. Frictional NJ tube
Features innovative flaps or barbs which allow peristalsis to gently drag the catheter into the jejunum
Organ Donation

Writing on the eve of the World Organ Donation Day on 13th August 2016, I often wonder if we as an Intensive Care Community in India have realized our potential in contributing towards Brain Death Donors Often called as (Cadaveric Organ Donation Program), India is ranked approximately 40th in terms of organ donation rates in the world. With Spain leading the world at around 34 Brain Death Donors to a million populations, we in India are at 0.05 Donors per million populations. This is despite having Transplant of Human Organ ACT – TOHA in place since 1994 and having had some amendments in 2008 and 2011 respectively, with some new rules introduced in 2014. Few states like Tamil Nadu have adopted the amendments and are leading the path in the country with approximately 1.9 Donors per million Populations. Though not reflective on waiting list, it is widely believed that there is a need for approximately 150,000 Kidneys, 50,000 Livers and perhaps similar number of Hearts in India. In compared to above, brain death donors per year are minuscule and unless the numbers increase the gap between need and availability of Organs will keep on increasing. The only place where brain death donors are the 3 main clinicians, registered hospital and appropriate authorities will permit to declare brain death. Along with 2-separate set of test done 6 hours apart by one of the above 3 clinicians, head of hospital administration and the primary consultant under who patient is admitted are also a part of the brain death declaring team. This clearly reflects the responsibility we as Intensivist carry on our shoulders in this process of Brain Death Donations. The ground reality is that we are way behind in identifying this as a priority in our day-to-day clinical practice. There are obviously several reasons for this, shortage of trained Intensivist across the country, ever growing patients and their complex management needs and increasingly difficult life an intensivist lives trying to balance between patients, hospital, family and continued professional development. All this has left organ donation to be one of the many jobs an Intensivist is supposed to do. Quite obviously with the process been time consuming, requiring complex communication skills and often dealing with variably emotionally labile families, it does take a toll on the person involved in the process. Having said that we as the Torch Bearers of Intensive Care Units have a responsibility just similar to what we perceive to be for example ventilating a patient. Every Intensivist should take a lead in organ donation process, identify patients and then successfully declare a patient brain dead. This will comply with the government initiative of declaring patient brain death and reporting the deaths. The next question comes of obtaining the consent. It is very well identified that the consent improves when there is a dedicated organ donor coordinator involved in the process. All hospitals registered to be Retrieval and Transplant centers are mandated to have organ donor transplant coordinators. This has definitely improved the consent rates and helped in more organs been available for transplantation.

Few of us may have a potential situation where there may be a perceived conflict of interest. This is seen in large transplant centres where the donor and recipient may be in the same ICU. Fortunately in these big units there is often a second intensivist who could help in manage either the donor or recipient and thus avoid conflict of interest. The second question asked is what if family refuses consent. In such an scenario if the patient has been declared dead then, withdrawal or ventilator or Inotropes will not amount to any violation of our law as the patient is legally dead and there is no legal obligation to continue treatment. However individual hospitals need to develop local policies, which will support the doctors in an eventuality of any litigation.

I wish to sign off by requesting all my colleagues to consider organ donation on same pedestal as we consider other ICU priorities to be.

Heart Transplant-
The Final Frontier

The heart transplant program for a hospital is the epitome of demonstration of quality care been delivered to patients. Though it is a program, which involves several disciplines - Cardiac surgery, Cardiology, Intensive Care, Anesthesiology, Infectious Diseases, Psychiatry, Blood Bank, Laboratory, Social workers, Nursing, Physiotherapy etc. It is the Intensive Care where the action takes place the most, after operating room and also longest as it continues for few days.

The stakes are high as there is a life at stake and unlike other organ transplant; Orthotopic heart transplant (removing recipients own heart and replacing with donors) is the norm as opposed to a very rare Heterotopic (where both hearts are connected to effectively form a double heart). Hence the desire to succeed is very high as we have removed the recipient’s own heart and any small error can lead to disastrous complications including death.

The preparedness of any heart transplant intensive care unit is time consuming and a laborious process. Though it may be possible to overnight prepare the ICU for a one off heart transplant, to make the program sustainable and successful there are robust processes before venturing for heart transplant. The nurses when managing such complex patients are automatically trained to achieve excellence because without them success is not possible. Once the ICU has reached that level where all the equipment and manpower is geared to manage various aspects of Intensive Care then the next leap is considered.

Without demonstrating willingness in process of Organ Donation, no ICU can achieve any success in a Transplant medicine. The Organ Donation program is the one, which need to be developed with the hospital. This is not necessarily to procure organs for our own patients, but to understand the complexities of Brain Death, diagnosis, declaration and donor maintenance. Seldom you would have a heart been allocated by the government agency like (ZFC) to you own hospital, but in this case of rarity it is ethically important to have two (2) separate teams in place one each for donor and recipient, so that conflict of interest does not arise.

The next crucial step is to identify the correct recipient. This is certainly a multi disciplinary task with the Cardiac Surgeon, Cardiologist and Intensivist playing an important role in...
investigating the recipient and only listing those patients who need a transplant and are likely to benefit from the surgery. The patients who may be refused are who still have a reasonable native heart function to give them a reasonable quality of life, patients who have multi organ failure and people who may need a heart lung transplant (which is usually the next step). The potential recipients are investigated, including panel reactive antibody to identify the one with high risk of rejection. A cardiac Catheterization to understand all the pressures, including the most important pulmonary pressures is undertaken. The next phase is of optimization of patient until he receives a new heart. This process is often heart and importantly variable for each patient as the availability of donor could be of different blood groups and varying weight and body structure which may not be suitable to the next in waiting recipient. Some recipients may be in hospital on Vasopressors or Inotropes, some have to be supported with ECMO of Left Ventricular Assist Device just to bridge them for transplant. Ambulatory milrinone therapy has been successfully used in a large group of patients who stay at home or do some work with an ongoing milrinone infusion. Having endeavored such diverse problems when a recipient is informed of a likely transplant it is like imagining a re birth for him or her.

The actual day of transplant is like an adventure and a story in itself; each so different from other that it is difficult to write a uniform process. What does remain unchanged is the Operation and Postoperative care in ICU. The first few hours are race against time. If the initial part is to for the donor hospital/ICU to maintain donor to the best of physiology, the recipient team; once the heart is allocated is working towards planning the transplant, need for perioperative supports, like nitric oxide etc for the recipient. The coordinated effort of retrieving the organs and then racing to the recipient, more so if it’s a inter city/state transport requires a lot of support, coordination and a ton of permissions from government authorities, forming green corridor, police, hospital coordination etc. With all this organized chaos the doctors strive hard to complete the transplant within 4 hours of donation and the patient is ultimately shifted to ICU.

In intensive care along with the marvel of changing physiology on the monitor, immunosupression. Thankfully the wheel is integrated into this Bill.

The physician is duty bound by current medical interventions even if futile. In the present day world, withdrawal and withholding decisions as the agency causing the patient’s death is the terminal illness not the decision to withdraw or withhold. It is a decision not to struggle or not to prolong a process already started. If done so as confusion with suicide and its abetment.

3. Since the right to refuse or accept treatment is fundamental right of a patient’s as a citizen, the imperative of consent before any medical intervention implicitly allows for refusal. Therefore all life saving interventions in principle can be refused/declined by the patient. So withdrawal and withholding of life supporting interventions can be refused if unwanted. If the context is terminal illness then the doctor can medically agree with such decisions. This can scarcely be confused with euthanasia or its variants as the agency causing the patient’s death is the terminal illness not the decision to withdraw or withhold. It is a decision not to struggle or not to prolong a process already started. If done so as confusion with suicide and its abetment.

4. Critical care units are the likely places where the urban citizen would usually die. Usually in the last days he/she is subjected to highly technological and expensive medical interventions even if futile. In the present day world, withdrawal and withholding decisions as the agency causing the patient’s death is the terminal illness not the decision to withdraw or withhold. It is a decision not to struggle or not to prolong a process already started. If done so as confusion with suicide and its abetment.

6. End of life decisions are essentially medical decisions. In the Aruna Shanbaug case the Amicus Curiae termed appropriate withholding and withdrawal decisions as "ordinary medical decisions that can be taken even without legislation". These observations should be integrated into this Bill.
ELICIT Public Meeting on 12th July
"Perspectives on Death & Dying"

The EliCIT Task force consists of (alphabetical order) Dr Jigi Divatia, Dr Vinay Goyal, Ms Harmala Gupta, Dr Roop Gursahani, Dr Shivakumar Iyer, Dr Stanley Macaden, Dr Raj K Mani, Dr U Meenakshisundaram, Dr T M Mohendradda, Dr Mary Ann Mukkaden, Dr Apoorva Pauranik, Dr Naveen Salins, Dr Nagesh Simha, Dr Mary Ann Muckaden, Dr Apoorva Puranik, Dr Naveen Salins, Dr Nagesh Simha, Dr Gagandeep Singh and Dr Nirmal Surya.

The ELICIT Task Force held the town hall meeting in Delhi, on the 10th of July 2016, with participation from intensive care specialists, neurologists, palliative care specialists, lawyers and laypersons including volunteers from cancer support groups, relatives of patients who had passed away, members of the press and many others.

Patient and Care-Giver’s Perspective as Title

The meeting was held as a series of panel discussions. Several open ended questions were asked to members of the panels and a lively interaction with the audience followed. Dr Roop Gursahani, one of the members of the executive committee of ELICIT expertly conducted the meeting.

The first panel examined questions related to the patient’s and the care-giver’s perspective. The panelists were Harmala Gupta from “CanSupport”, Priya Jain, Dr. Nagesh Simha, a palliative care specialist and an executive committee member of ELICIT and Dr. Ajjit Mansingh an ENT surgeon.

Dr. Roop started the ball rolling by asking Dr. Mansingh to narrate his experience of having someone close pass away. Dr. Mansingh explained to the audience his experience of caring for his mother who had advanced Parkinson’s disease and later his father who had a disseminated cancer. He explicitly stated that having a method to record the wishes of his parents would have helped him in the difficult decision making especially regarding “do not resuscitate” and “withholding withdrawing” therapy. Amazingly though Dr. Mansingh and his father had not had a detailed discussion about his prognosis, his father however being a medical person knew his diagnosis and probably knew the prognosis. He recalled the final chance conversation that they had towards the end, that he cherishes in his heart today.

Dr. Simha then narrated his personal experience of being in an ICU when he underwent renal transplantation and related the stages a patient goes through while dealing with the disclosure of a life threatening diagnosis.

A lady from the audience narrated her experience of looking after her terminally ill mother after she was discharged from Tata Hospital. Palliative Care team from CanSupport whom she approached, gave proactive advice and support to the family, preparing their minds and their home to care and look after her mother at home without distress. Their continued engagement allowed conversations within the home about her mother’s terminal condition which helped her mother open out to her children and her husband and express her wishes and achieve closure for many unfinished issues.

Dr. Simha then explained to the audience about an evidence based approach for breaking bad news to patients and their families. He explained how a semi structured conversational approach (SPIKES) consisting of Setting up an interview, Assessment of patient perspectives, ensuring Invitation for information sharing from the patient, transfer of the information, i.e. Knowledge in an Empathetic manner and Summarising and Strategising for immediate future.

Dr. Purnima Karandikar narrated her experience of looking after a patient who was given a terminal diagnosis in the ICU when he underwent renal transplantation and related the stages a patient goes through while dealing with the disclosure of a life threatening diagnosis.

Dr. Mansingh then explained to the audience about the need for a well structured and simple to understand tool. She emphasized the importance of facilitating the opportunity for the patients to say – I love you, I am sorry, I forgive you and goodbye to the loved ones in their lives, before they make their final exit.

The Doctor’s Perspective

The second panel looked at questions related to the doctor’s perspective. The panelists were Raj Mani (intensive care specialist), Shivakumar Iyer (anaesthesiologist, intensivist) Sushma Bhatnagar (Palliative Care Physician) and Sanjay Nagral (gastroenterology surgeon and ethicist)

Roop began by asking Dr. Mani to comment on the process of dying and the common trajectories of dying in terminally ill patients. Dr. Mani described four common scenarios; i) patients with organ system failure who go downhill punctuated with episodes of acute worsening, each episode worsening the baseline status, ii) patients with organ system failure who function at a low baseline for a prolonged period and progressively decline or may develop multiple alterations on email the final draft to DSK legal to prepare an alternate draft bill on behalf of ISCCM. Dr. Atul Kulkarni, Dr. Pradip Bhattacharya could unfortunately not attend this meeting.

The Doctor’s Perspective

The second panel looked at questions related to the doctor’s perspective. The panelists were Raj Mani (intensive care specialist), Shivakumar Iyer (anaesthesiologist, intensivist) Sushma Bhatnagar (Palliative Care Physician) and Sanjay Nagral (gastroenterology surgeon and ethicist)

Roop began by asking Dr. Mani to comment on the process of dying and the common trajectories of dying in terminally ill patients. Dr. Mani described four common scenarios; i) patients with organ system failure who go downhill punctuated with episodes of acute worsening, each episode worsening the baseline status, ii) patients with organ system failure like congestive heart failure, liver failure, COPD who go downhill punctuated with episodes of acute worsening, each episode worsening the baseline status, iii) patients with dementia, other neurological disorders who function at a low baseline for a prolonged period and progressively decline or may develop
The CriTiC al Care CommuniC aTions   a Bi-monThly newsleTTer of indian soCieTy of CriTiC al Care mediCine

train patient's families to provide care at home

be done at home for terminally ill patients. Dr. Roop then asked if it is possible to identify the trajectory individual patients might take and whether it would be possible to provide care at home for all patients. The rapid increase in home deaths is increasingly becoming possible to anticipate a poor prognosis in such conditions and change goals of care accordingly, although not with accuracy in terms of time. Dr. Iyer responded by saying that it was easier to predict progression of critical illnesses than the unpredictable "surprise question" i.e. 'would I be surprised, if this patient were die in the next few weeks or months' as recommended by the Gold standard Framework, UK.

Dr. Roop then asked Dr. Sushma Bhatnagar to describe what she would consider a good death. Dr. Sushma stated that a death in which suffering is minimized by good symptom control, where unnecessary interventions are avoided and the patient is informed as per his choice and enables to achieve closeness and care in the company of her/his near and dear ones may be described as a good death.

Dr. Iyer when asked about different approaches to decision making that patients choose, at the End-of-life, quoted results of a study that examined decision styles of patients with terminal illness. It showed that patients may be divided into those who like to decide for themselves and those who like others to decide for them. Those who like to decide for themselves are described as authorizers who would like to specify whom they want to decide for them, or as absolute trustees when they are generally trusting and wouldn’t mind if anybody in their families at their doctor decide for them. Avoiders are those who feel powerless and therefore avoid decision-making till the very end and allow decision making happen by default (or by God) as they feel completely helpless. Those who are not making decisions could be benefited by an individualized approach to end-of-life decision-making.

Sanjay Nagral explained about brain death in response to a question by Roop. He explained how in India, a utilitarian perspective of approach to end-of-life decision-making. For doctors it was more often fears of litigation that mattered while patients mentioned people more often harbour fears of the process leading to death of “how I will die, will I suffer” etc. rather than the fear of death itself. For doctors it was more often fears of litigation that prevented them from reaching appropriate EOLC decisions for critically ill patients. Dr. Mani then said that it is important to understand the psyche of the people we are addressing, when planning strategies. Dr. Nandini related this to her experience in planning strategies where people more often harbour fears of the process leading to death of “how I will die, will I suffer” etc. rather than the fear of death itself. She related this to her experience in planning strategies where people more often harbour fears of the process leading to death of “how I will die, will I suffer” etc. rather than the fear of death itself. Dr. Roop then concluded the session by saying that one euthanizes animals in the appropriate context and not sentient human beings who can decide for themselves.

EOLC as a Public Campaign

The third panel discussed End of Life Care as a Public Campaign. The panelists included Nandini Vallath (Co-Founder, Institute of Palliative Sciences), Anita Anand (ComFirst India Pvt Ltd), Apoorva Puranik (neurologist), and Vinita Singh (Independent Consultant, Ethical Trade; Trustee, WeThePeople).

Dr. Roop began this panel discussion by asking Dr. Nandini Vallath about how Kerala became a shining spot in the otherwise dismal rating that India received in the Quality of End of Life Care survey of the “Economic Intelligence Unit”.

Dr. Nandini explained how concerned deliberations amongst three friends, Dr. Rajagopal, Dr. Suresh Kumar and Mr. Ashok in a pain clinic in Calicut Medical College in the late 1980s, went on to develop Pain and Palliative Care Society, which provided palliative care services and training, and later extended their work to the community with the help of satisfied family carers, volunteers and with sustained media support (Malayalam Manorama), television. She explained the committed movement within community garnered government attention and facilitated the State Palliative Care policy for Kerala after two decades of work. Through his policy, the government of Kerala commits to access and availability of palliative care to its citizens through its network of healthcare services.

She went on to say that although palliative care was well established in the community, there are significant gaps in care especially for non-cancer patients, acute illnesses and for patients in multi-specialty hospital settings. She narrated her experience in India with COPD, with wished that he had cancer rather than COPD so that he could receive some palliative care. She emphasized through two patient scenarios, how ongoing conversations between the patient/family empowered with clarity no what is going on, and the doctor, enables honest communications and clarity on what an intervention can and cannot do. She pronounced this to be ‘the cru to appropriate care planning, and for dignified end of life care. Vinita Singh underlined the importance in the Constitution to the people and said that it was important to appreciate the directive principles enshrined in our constitution and how they can become a starting point for our dialogue with people regarding end of life care. The constitution provides for the unity in diversity in our country. She was full of praise for the Indian constitution as an extraordinary document that acknowledges the vastness and diversity of this ancient country, and yet has retained it’s soul, the oneness that ties us all together, at it’s very core. Its structure and contents have strengthened our ethical and legal framework. Anita Anand was asked by Roop “How can we get a media and communication strategy for this issue?” Anita answered by saying it is not just about living well, but also about the individual’s perspective regarding life and death. All of us are going to die, acceptance is the key, of death as a part of the life cycle. She added that the Hindu view about rebirth and reincarnation helped in the campaign for the newly drafted law on euthanasia. Arundhati Roy commented on how in India, a utilitarian perspective of approach to end-of-life decision-making.

Sanjay Nagral explained about brain death in response to a question by Roop. He explained how in India, a utilitarian perspective of approach to end-of-life decision-making. For doctors it was more often fears of litigation that prevented them from reaching appropriate EOLC decisions for critically ill patients.
and emphasized that we have to know how to communicate with our patients in these issues and literacy is not an issue. Deepa George from the audience added that if we can understand death, then we would have understood life.

Dr. Apoorva Pouranik talked about the importance of addressing and allaying misconceptions among laypersons and legal fraternity that such laws may become a Licence to kill. Swagata Banik a public health care professional related from his US based experience that EOL Care should be seen more as a public health issue. He offered his help for doing collaborative research for bringing out the vast empirical data in EOLC from India. He also made the observation that nursing and faith leaders are missing in our dialogue regarding EOLC. Dr. Roop concluded the panel discussion by stating statistics of the growing single person households, which is currently at 5% in India, 15% in China and 25% in South Korea. This is going to pose significant challenges to the future for care planning especially at the terminal stages.

EOLC and the Law

The fourth panel discussed End of life care and the law. The panelists were all lawyers of repute-Girish Gokhale, Vivek Diwan and Nausher Kohli Roop initiated this panel by asking Mr. Girish Gokhale what exactly are the rights of patients with regard to end of life care and he replied saying that the constitution is an aspirational document and the fundamental rights have in many ways guided important laws protecting citizen liberty. He stated that the right to life is the right to live with dignity, until the point of death. There is no separate right to autonomy but the right to give consent or refuse it may imply this right to autonomy. To this Dr. Mani remarked that the Preamble to the Constitution of India assures “Liberty, Equality and Fraternity”. Autonomy is implicit in the Right to Liberty.

Dr. Roop then asked Nausher about how the ELICIT draft bill was prepared? Nausher then described in detail the preparation of the draft bill by DSK legal team, by studying the prevalent laws of scores of countries and in consultation with Dr. Mani, Dr. Roop and Dr. Simha. This draft was then circulated among the ELICIT members on email and after multiple iterations a final draft was collated and circulated by Dr. Naveen Salins. This reviewed draft was discussed in detail, in a meeting on 9th July and the final draft bill is now with the legal team, getting ready for submission to the federal government.

In the open question answer session that followed, Vinita Singh stressed on separating strategies that focused on creating awareness in the community, the legal fraternity and doctors.

Dr. Roop then posed a question about Sallekhana, Santhara and other methods of voluntary choices of death in the Indian tradition, by giving up eating and drinking to allow death to occur gradually. Mr. Prassananshu, a lawyer in Delhi from the Indian law school then elaborated about Sallekhana, santhara, Samadhi, iccha mitruy in the Indian tradition. He explained how respect for autonomy is emphasized in these traditions. Santhara is usually undertaken when end of life is perceived to be near. Starvation and abstinence from food and water is the usual method. The decision is not irrevocable. The sanction of religion exists along with processes to examine the motive for Santhara in individuals. It can be disallowed by the religious leaders if the motive is suspect. A chance of misuse however persists.

After this last comment Dr. Roop Gursahani thanked all the panelists and the audience for their active participation and Dr. Mani then thanked Dr. Roop for his expertise in organizing and coordinating the event and the meeting came to a close.

Dr. Shivakumar Iyer (suchetabiva@gmail.com)
Dr. Nandini Vallath (amanandini@gmail.com)
Dr. Poomima Karandikar (poomima.poonam@gmail.com)

Critical Care Nursing: Empowering Nurses - through Continuing Nursing Education

“Any intelligent fool can make things bigger, more complex, and more violent. It takes a touch of genius — and a lot of courage to move in the opposite direction.”

- Ernst F. Schumacher

From caring for critically ill patients in the most anarchic situations to implementing synergistic strategies that focused on creating awareness in the community, the legal fraternity and doctors.

Dr. Khusrav Bajan
Critical Care Consultant & Head of Emergency Department
Hinduja Hospital, Mumbai

“Intelligent Nursing Care” to patients with varied disease processes & care needs. A Continuing Nursing Education (CNE) in Critical care, forms a canopy of enrichment systems for betterment of Critical Care Nursing practices in Healthcare. Understanding this need & urgency of having well-trained Nursing professionals rendering quality care to critical patients in India; a Continuing Nursing education endeavour was initiated by ISCCM, through the “Indian Diploma in Critical Care Nursing” (IDCCN). This was rolled out as a pan India initiative has grown by leaps and bounds since its inception (in 2013), networking & impacting not only the urban healthcare setting but also the rural healthcare in India. In accordance to attrition of Nurses from India and a huge lacunae of trained Critical Care nurses, the ISCCM, has now cut down on the IDCCN course fees drastically to generate this CNE to the most remote areas of healthcare.

If Doctors are the “Minds” behind the decision making, Nurses are the “Indispensable channels of Care” and one can never have favourable patient outcomes, without a “Stratified & integrated team approach”.

Nursing Empowerment through education and training leads the Critical Care Nurse to “Think”, “Question”, “Research” and “Implement” Critical care practices to positively impact Nurse-led Patient outcomes in the most synergistic manner.

Winners of Critiquiz 2016-2017 “Battle of the Brains” - Episode 2

Dr. Payel Bose
FNB CCM Trainee
Rabindranath Tagore International Institute of Cardiac Sciences, Kolkata

Dr. Gunjan Chanchalani
MD, FNB, IFCCM (Critical Care Medicine)
Chief Intensivist
Nanavati Hospital

Winners of first episode get free registration for First ICCMID Course on 10-11 September, 2016 at Delhi.

3th - 10th July 2016 • Pune, INDIA

Jointly Organized by
ISCCM, Pune Branch &
the Department of Intensive Care, Erasme University Hospital, Brussels

7 Pre-conference hands on workshops were held from 3th– 7th July 2016

Course: 14th Annual Review Course on Intensive Care
3th, 4th & 5th July 2016
5th Floor, Ruby Hall Clinic & Mock Test at Tehmi Grant Nursing School
Delegates: 150 • Course Director: Dr Balasaheb Pawar
Co-Directors: Dr Sunitha Binu Varghese & Dr Sushma Patil Gurav
This year at the review course one day was dedicated for Mock examination designed to prepare trainees for practical & theory exit examination in critical care medicine. The objectives were to expose them to an exam environment, understanding the pattern of examination, what is expected, give a feed back after each interaction of what was good and what was missing and most importantly to be examined by ISCCM examiners. The pattern selected has consists of a mixture of written MQC, Cases discussions, didactic lectures and table viva to give a comprehensive exposure to all components of examination

Workshop / Course: 20th Annual Fundamentals in Mechanical Ventilation
6th & 7th July 2016 • Hyatt Regency, Pune
Delegates: 131 • Course Director: Dr Sandhya Talekar • Co Director: Dr B D Bande
This Mechanical Ventilation Workshop focused on the fundamental aspects of Mechanical Ventilation. Some of the topics that were covered at this workshop included Modes of Ventilation, Trouble Shooting, Airway Management, NIV, Ventilation in COPD, ARDS

Workshop / Course: 3rd Annual Advanced Strategies in Mechanical Ventilation
6th & 7th July 2016 • Hyatt Regency, Pune
Delegates: 52 • Course Director: Dr Sandhya Talekar • Co Director: Dr B D Bande
This workshop was an advanced mechanical ventilation workshop covering new emerging technologies in Mechanical Ventilation and Gas Exchange. Some of the topics that were discussed were Electrical Impedance Therapy –ASV, EIT, ECMO, ECCO2R, ASV, HFO, Trans Pulmonary Pressure, and Newer Modes of Ventilation. The new experiment of the “advanced strategies” showed a lot of promise and exclusiveness

Workshop / Course: Hemodynamic Monitoring
6th & 7th July 2016 • Hyatt Regency, Pune
Delegates: 83 • Course Directors: Dr Kayanoosh Kadapatti
Course Coordinator: Dr Jyoti Shendge
The only Hemodynamic Monitoring workshop in the country to have 5 international Faculty. During this workshop various invasive and non invasive techniques of hemodynamic monitoring and Cardiac output measurement like CVP, Arterial pressure and PA pressure monitoring, Pulse Contour Analysis, Echo-cardiography & Doppler were discussed
A joint venture training program of ISCCM Pune Branch & WINFOCUS, delegates were trained in using Ultrasound according to 'ABCDE' and 'Head to-toes' priority pathways in order to enhance rapid and effective decision making, diagnosing, treating, and monitoring acute and critical ill patients. The course covered general principles of ultrasound, how to interpret the ultrasound patterns of the major acute syndromes, and the technique of the major invasive procedures. The delegates also had hands on practice sessions so as to make them comfortable to use ultrasound in critical care. This well structured workshop helped delegates to use of USG & 2DEcho in septic shock, ARDS, pulmonary embolism, acute decompensation of Heart Failure and many more complex scenarios.

WORKSHOP / COURSE: Clinical Nutrition
6th July 2016 • Hyatt Regency, Pune
Delegates: 73 • Course Director: Dr Subhal Dixit
This workshop aimed to develop a strategy for team work for the Intensivist, dietician & nurse. Delegates were able to understand Principles of nutritional support in ICU, monitor nutrition in ICU, Practical aspects of enteral /parenteral nutrition and trouble shooting. Disease specific nutrition Immunonutrition, organizational aspects of nutrition support, nutritional products and delivery system, the participants also got an opportunity to interact with experts during the hands on session. This workshop was aimed to develop a real sense of team work in the ICU and this team of the intensivist, dietician & nursing staff has a true awareness about the importance of nutrition in the critically ill.

WORKSHOP / COURSE: Straight Talk
7th July 2016 • Hyatt Regency, Pune
Delegates: 66 • Course Director: Dr Kapil Zirpe, Dr Ashit Hegde & Dr Sushrut Bandopadhyay
For the first time a new workshop “Straight Talk” which was linked to antibiotic resistant &addressed factors including economic impact, intrinsic and acquired drug resistance, morbidity and mortality rates, and causes of infections were taken into account. Synchronously with the waxing of bacterial resistance there has been waning antibiotic development. The approaches that ID specialist are employing in the pursuit of new antibacterial agents were briefly described. The attendees got an overview of current scenario of infections, important bug,preventive strategies, the antibiotics –, mechanisms of action and resistance, spectrum of activity, and preeminent members of each class are discussed.

The Fourth Annual “BEST OF BRUSSELS” Symposium on Intensive Care & Emergency Medicine held in Pune, India
8th to 10th July 2016 • Hyatt Regency, Pune
ISCCM, Pune Branch under the chairmanship of Dr Shirish Prayag & Prof Jean L Vincent has successfully conducted the Fourth Annual “BEST OF BRUSSELS” symposiumin PUNE, India from the 8th to the 10th July 2016 at the Hyatt Regency, Pune.

Our brand new JAMA Session in BOB 2016
This year we had planned an exclusive new JAMA Session simply means -Just Ask Me Anything which was held on 8th July 2016.It was truly interactive open live forum with all 12 faculty members on the dais. There were No presentations, No talks, No debates; just an hour-long Q&A session with world renowned professors. Delegates could just ask any question to the faculty and they got the best possible answers from these SMARTYDOZEN!!

The traditional Lamp lighting ceremony

Twelve International Faculty on the dias - Jama Session
The brain storming Scientific Sessions: The Brilliant Dozen……………………………in process………. The “ Translational session ” which was held on Sunday 10th July, had National & International experts hold discussions on topics of major presentations made during the preceding 2 days of BOB, which was case based and interactive with the audience. This session was aimed to convert the points at the BOB sessions in to real TAKE HOME Messages related to cases that we see in our ICU’s. This session was rated as the most welcome and useful change by all the delegates as well as International and National faculty.
The CriTiC al Care CommuniC aTions  
A Bi-monThly newsleTTer of indian soCieTy of CriTiC al Care mediCine

The Moderators  
Prof J L Vincent & Dr Shirish Prayag

Dr Urvl Shukla  
presenting a case on Difficult to wean

The EXPERTS:  
Prof Davide Chiumello & Dr Rajesh Chauola

Dr Sameer Jg presenting a case on MI with Cardiogenic shock

The EXPERTS:  
Prof Jean Louis Teboul & Dr Yatin Mehta

Dr Subhal Dixit  
presenting a case on GI Blood

The EXPERTS:  
Prof Daniel DeBacker & Dr Pravin Amin

Dr Sunitha Varghese  
presenting a case on Resistant organisms, long standing ICU

The EXPERTS:  
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Dr Kapil Zirpe presenting a case on Infections in Organ transplant recipient

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The Team behind it !!!!!!!!!!!!!!!
2nd International Conference on Imaging in Critical Care Medicine

Organized by
Indian Society of Critical Care Medicine, Kolkata Branch
17th-20th November 2016 • Novotel, Kolkata

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Dates To Remember

Conference Secretariat
Event Managers

Workshop
1st & 2nd Feb, 2017

Presidential Oration
3rd Feb, 2017

Presidential Dinner
3rd Feb 2017

Faculty Dinner
1st & 2nd Feb, 2017

Exhibition Opening
2nd Feb, 2017 @ 5.30 PM

Banquet
4th Feb, 2017

Conference Inauguration
3rd Feb, 2017

Venue Images
Crowne Plaza, Kochi
Le Meridien, Kochi

Travel And Tour Operator
Criticare-2017
23\textsuperscript{rd} Annual Conference of Indian Society of Critical Care Medicine

Workshop  
1st, 2nd February 2017

Conference  
3rd, 4th, 5th February 2017