# Pediatric Intensive Care Nursing

***Newsletter of the International Pediatric Intensive Care Nursing Network***

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*Page layout design by Marisa Picciano*

# *Editorial*

## Pediatric Intensive Care Nurses are coming together in Boston

*Franco A. Carnevale RN, PhD*
*Editor*
*Head Nurse, PICU*
*Montreal Children's Hospital*
*Montreal, Canada*

This coming June (June 8-12, 2003) our colleagues in Boston will be hosting the 4th World Congress on Pediatric Intensive Care. This is a unique event that brings together nurses, physicians and other professionals and researchers from around the world to exchange experience and ideas. This is an exceptional event.

The previous World Congress, which was held in Montreal (June 2000), was a tremendous success that gave rise to numerous exciting initiatives. In addition to the depth of the dialogue permitted by the Congress, this converging of nurses from around the globe helped launch the *International Pediatric Intensive Care Nursing Network* (a group that we envisage will someday become further formalized into an association). This group called for a forum within which the exciting exchanges from the Congress could be further sustained. Thus, the egroup *PICU-Nurse-International* was created on July 4th, 2000. This egroup presently has over 300 members from well over 20 countries from every continent (except Antarctica).

This group has further created an international electronic publication – this newsletter – *Pediatric Intensive Care Nursing* which is managed by our International Editorial Board (the newsletter is indexed in CINAHL, the electronic database for nursing literature).

The world of pediatric intensive care nursing is vibrant and is increasingly coming closer and closer together as a community, while each region retains its very distinct nature. We hope that many of our readers will be able to attend this special event. For the many of you that cannot, you can count on being able to read all about it in this Newsletter!

## Bali – A View From Australia

*Beverley Copnell, RN, RSCN, BappSc.*
*Senior Research Assistant, School of Postgraduate Nursing, University of Melbourne, Melbourne, Australia*

**Abstract**

This paper describes events following the October 2002 bombings in Bali. In particular, the extraordinary amount of severe injuries transported to Australia for critical care is described. This is referred to as the largest disaster encountered by Australia in its modern history.

**The Australian Experience**

On October 12, Australians found out what Americans discovered last year – how it feels when terrorism comes to our own backyard. Other than the scale, there were two main differences between this attack and September 11: first, there was a significant number of critically injured survivors, and second, it happened in a city that lacks the facilities to care for them. The majority of the survivors were evacuated, with commendable speed, to Australian hospitals – most to Darwin, in the Northern Territory.

Ronnie Taylor is the Trauma Nurse Consultant at the Royal Darwin Hospital Emergency Department (ED). On October 18 she posted the following message to the Emergency Nurses' List. With her permission I reproduce it here.

"A little over 24 hours ago I saw the 59th victim of the Bali bombings, out of 61 that came through my ED doors. These patients arrived to us en masse in 3 waves 24 hours after the bombings. Our closest major ED in Australia is at the Royal Adelaide Hospital, 3000 kilometers away, hence there was no going on bypass. We were it.

I spent the time from 0100 hours Sunday to 1700 hours Monday triaging 59 patients into our little 20-bed unit. We usually see 40,000 patients a year, many of those road trauma victims, so we are very familiar with big trauma, but never on this magnitude.

Sunday night my staff dealt with 16 unstable, critical patients with multiple blast injuries. We admitted 12 to our ICU, some straight to theatre, and within 24 hours we had evacuated about 40 patients around Australia. There are 5 major burn centres in Australia, and these people need major plastic surgery.

It is the largest disaster in modern history in Australia, I believe with more injuries than the Oklahoma bombing, and the burns are on a par with 9/11. Besides the major burns, we had fractures, amputations, eye injuries, blasted tympanic membranes, crush injuries.....etc. The burns are horrific, many greater than 80%, many more greater than 50%. There is no air conditioning in the sweltering heat of Denpasar hospitals; supplies of fluids, tetanus vaccine and morphine are stretched to the limit. By the time we saw our first victims, many were very poorly fluid resuscitated, and many had infections setting in.

The team of ED staff was superbly complemented by the army, ICU, ambulance, and other ward staff. We did our utmost to relieve some of the unbearable pain and suffering, predominantly fellow Australians, but a number of UK citizens, Canadian, and European patients also. All just innocent victims of an atrocious terrorist attack. My country has many missing, many dead. Per

capita, it is as big as 9/11 to the US population."

As citizens, we shared the emotions of the rest of the country: shock, outrage, and grief. As paediatric nurses, we also felt relief that no children were severely injured, and we did not have to share first-hand in the experiences that Ronnie described. As nurses, we acknowledge the efforts of our colleagues in caring for the survivors. It is a tribute to their skills and knowledge that most of them are still alive.

# Moral binds and conflicts of interests: Ethical considerations for innovative therapies

*Franco A. Carnevale, R.N., Ph.D.*
*Head Nurse, Pediatric Intensive Care Unit, Montreal Children's Hospital*
*Associate Professor, McGill University*
*Montreal, Quebec, Canada*

**Abstract**

Complex ethical considerations involved in decision-making regarding the introduction of innovative therapies are discussed. These are related to a case study of a 10 year old boy with chronic cholestatic disease (listed for a liver transplant) that has been admitted to the PICU with an acute deterioration of liver function and hepatic encephalopathy. The gastroenterology service proposes using an innovative therapy: the molecular adsorbent recirculating system (MARS) - a cell-free, extracorporeal, liver-assistance method for the selective removal of albumin-bound metabolites.

This article is adapted from a presentation at the conference *Reasserting Ethical Values in the Context of Scarce Resources* in Montreal on November 27, 2003. The presentation started with the following case study which was followed by the author's ethical analysis in the comments that follow.

## I. A Case Involving Innovative Therapies: A Good for Recipients vs. a Burden for Others?

You have been called to a meeting to review the following problem. William is a 10 year old boy with chronic cholestatic disease that has been on a liver transplant list for some time. He has been admitted to the PICU with an acute deterioration of liver function and hepatic encephalopathy (i.e. impaired cerebral function resulting from an over-accumulation of albumin-bound metabolites (such as bilirubin and bile acids normally regulated by the liver). He has a decreased level of consciousness and requires mechanical ventilation. His life is seriously imperiled, as well as the viability of his major organs such as his brain.

The gastroenterology service proposes using an innovative therapy: the molecular adsorbent recirculating system (MARS). This is a cell-free, extracorporeal, liver-assistance method for the selective removal of albumin-bound metabolites. This technology has emerged in Europe where a small body of evidence suggests that this can be successfully used as a bridge to transplant. Some reports have documented a quasi-immediate improvement in cerebral function.

It has been proposed that this technology can offer William a significantly improved likelihood of surviving until transplantation - especially considering that this ICU admission will move him to the top of the transplant list. Preliminary inquiries with Health Canada indicate that approval for the MARS on a compassionate use basis for this individual case would be possible.

However, this technology has never been used in Canada. The European supplier has offered to send a specialized team of a physician advisor and technologist to assist and train our team to utilize the MARS until we would be capable of managing it on our own. This also presents a promising opportunity for our Hospital to pioneer this new form of therapy.

The utilization of the MARS would however present some direct conflict with the provision of services to other children – given that the PICU is frequently full (at least one critical surgery is cancelled each week because of insufficient PICU beds), resources such as float nurses would have to be drawn for several other wards (including oncology and the emergency room) in order to help the PICU provide this

service. Consequently, the provision of services in various departments would likely be strained by this undertaking.

*Questions for discussion:*

1) Should the MARS be provided for William in our PICU?
2) How should such a decision be made – according to which standard and decisional process?

**II. Ethical Analysis: Outlining a process for ethically-sensitive innovation**

A parent once told me regarding his child's critical illness, "as long as there are options - there is hope."

I've worked in pediatric intensive care for a long time. Over the years, I've had the privilege to learn about the experiences of many critically ill children and their families - cases where many children survive - and far too many die.

On occasion, some parents retain highly pained memories surrounding some of the 'trial and error' decision making required by their children's complex condition. Citing one parental exemplar, one bereaved father told me,
"I believe that all these specialists are well-meaning people - but there was a time when I questioned that. they kept telling me that they couldn't explain why my Jessica wasn't getting better - but they would keep proposing new things to do - all the time saying it's hard to know if they'll help.

A part of me wanted to hear that there were still some options to try - as long as there are options, there is hope. But another part of me, looking at my little girl, wasting away day by day, felt like she was being used like a guinea pig - she was an object of medical curiosity, a puzzle, that everyone was keen to try to figure out, yet I could sense hardly anyone REALLY expected that puzzle would be solved. But as a parent, how could I live with myself to be the one to say no. But now that she has died, I often feel like I failed my little girl - I should have protected her from all that experimenting at the end" (end of quote).

Fortunately, these kinds of sentiments seem to be the exception. It's my impression that most families that have lived through such situations look back with a sense of comfort that everything that could be done was done for their precious child. However, this sentiment is expressed with so much regularity that I would speculate this may be part of a 'retrospective revisionist history making' - whereby each person is faced with constructing his/her own historical account in a manner that helps comfort extraordinary pain and grief. It seems to me that parents are torn by a fundamental moral tension - striving to be a good parent both prospectively as each case unfolds, and retrospectively as he/she struggles to find some coherent sense to the ruptures and chaos surrounding their frequently tortured lives.

*As long as there are options - there is hope.*

The case presented involves a consideration of an innovative therapy - one that is not within the existing standard of care. The prevalent view in bioethics regarding the care of children is that the best interests standard should be applied - weighing the benefits and burdens associated with each treatment option, in order to determine which option is in the CHILD's best interests.

But such a determination of the child's best interests is highly problematic because each person is compelled by his or her OWN interests - there are inescapable conflicts of interests.

Parents are torn between judging what is best for their child - sometimes in opposition to what they feel is their duty to do as a 'good' parent.

Professionals are also torn - trying to judge what is best for the patient - sometimes in opposition to understandable personal interests for a reasonable workload, rest, some comfort, getting on with other cases - which are sometimes also in opposition to academic interests in innovating and pursuing professional recognition.

The organization is also torn - wanting on the one hand that which best for each of its patients, while also trying to pursue other interests such as cost containment, or political strivings for political eminence.

*As long as there are options - there is hope.*
But what ought we hope for?
How do we determine what is best for the child? How do we reconcile the interests of

the child with this variety of potentially competing interests?

In light of the facts that (a) the child is typically unable to actively participate in such dialogue and speak directly to his/her own interests, and (b) the adult decision-makers are inescapably faced with conflicting interests - it is important to recognize that although parental permission or consent is necessary for treatment decisions involving innovative therapies, it is not sufficient.

An ethical management of such decisions requires the formulation and implementation of a decisional framework - a framework with procedural and normative components. In other words, a hospital policy should be developed that indicates what *procedure* should be followed for handling such decisions as well as what norms or standards should be applied by this procedure.

Although such a procedure should be developed formally by the organization, here is an example of what it *could* look like.

**A proposed policy for treatment decisions involving innovative therapies**

First, a consultation with the clinical ethicist should always be conducted. The ethicist should then judge whether the Clinical Ethics Committee should be convened to examine the case further.

Such a meeting should also include (if not already members of the Committee), at least one senior administrator, at least one senior member of the research ethics board (to assist with the analysis of the evidence supporting and contesting the proposed intervention - in relation to conventional care), a patient representative, along with the caregivers significantly involved with the case at hand. Parents should not be invited to such an initial meeting, because a determination needs to be made regarding whether this is an intervention that would even be considered plausible for this patient in this institution.

The principal standard upon which such a decision should be made is the child's best interests, as judged by the preliminary analysis conducted at this meeting - carefully weighing the existing evidence regarding the likely benefits and burdens related to the innovative therapy. This would be followed by a subsequent discussion with the parents regarding the options that the treating team considers reasonable to offer.

All of these discussions should seek to make transparent the entire range of interests implied in this decision and ensure that the child's best interests are prioritized. However, the remaining interests can also be considered meritorious - and should be seriously balanced in the case of a scenario where the child's interests in pursuing the innovative therapy are highly unclear or extremely marginal. The next, level of interests that bear upon the decision is the balancing of resources that are considered scarce – particularly where there is a potential or likely burden for other patients involved in undertaking the innovation.

Parental striving to be a good parent and staff's personal interests regarding their workload could be ranked next on a par level;

Academic interests to pursue innovation - outside the context of a structured approved research protocol could be on the next level - followed by the organization's political striving for eminence - which should come last, as it is most difficult to justify in terms of serving a morally recognized good.

I would not presume to consider this list of interests to be exhaustive, nor this ranking to be definitive - this is merely a sample framework for illustration purposes.

*As long as there are options - there is hope...*

It is important that we work proactively to determine and foster hopes that are morally grounded.

## Perth 2002 8th Paediatric and Neonatal Intensive Care Meeting

*Fenella Gill, Paediatric Nursing Convener*
*Nurse Educator, Pediatric Intensive Care Unit*
*Princess Margaret Hospital for Children, Perth, Australia*

This year in Perth the 27th Annual Scientific Meeting and 8th Paediatric and Neonatal Intensive Care Meeting were held concurrently from 18th to 20th October at the Sheraton Hotel in Perth, Western Australia. There were a number of reasons why a combined meeting was held including recognition of the expected smaller turnout and longer travelling times by delegates from Eastern States, and the relatively small number of PICU and NICU staff in WA. Combining the meetings appeared to be successful with a number of our adult ICU colleagues enjoying some of the paediatric/neonatal presentations, and paediatric delegates were also able to attend other sessions that, although not specific to paediatrics, were extremely relevant to their clinical practice. I understand that for Cairns in 2003 a similar format is planned.

The Perth 2002 keynote paediatric speakers were (medical) Ian Adatia, Director of the Childhood Pulmonary Hypertension Clinic and the Cardiac Critical Care Program at the Hospital for Sick Kids in Toronto, and (nursing) Jos Latour, Nurse Manager PICU, Vu Medical Centre Amsterdam. Until 2000 Jos Latour was the President of the European Society of Paediatric and Neonatal Intensive Care Nursing.

Both Ian Adatia and Jos Latour presented in the ASM plenary sessions. On the Friday and Saturday there were 4 paediatric/neonatal concurrent sessions: postoperative cardiac surgery, ventilation, neonatology, and sepsis. We were fortunate that Ian Adatia's wife was also able to attend our meeting, Lisa Hornberger, a cardiologist specialised in fetal echocardiography, gave two presentations during the meeting.

Jos Latour contributed greatly to the meeting by presenting on a number of topics including the development of the European guidelines for administration of Nitric Oxide, parental presence during CPR, the clinical impact of the legalisation of euthanasia in the Netherlands, and training and maintaining the critical care nursing workforce. In addition Jos presented at the Friday morning international paediatric nurses networking breakfast and at Princess Margaret Hospital earlier in the week. As well as his presentations, Jos stimulated much dialogue and enthusiasm for increasing our (Australian) international profile and establishing closer links with nursing organisations and colleagues around the world.

In this edition of you'll find a separate feature about the international paediatric nursing networking breakfast and the activities of the ACCCN paediatric special interest group (Paed SIG) meeting. The 2002 meeting in Perth was an important step in the development and in articulating the role and function of the Paed SIG. Thank you to Rod Hancock, Code Blue Nursing Agency for supporting us by sponsoring the breakfast and the Thursday night paediatric dinner beverages held at the Boatshed Restaurant in South Perth. The Paediatric dinner provided the opportunity for delegates from PICUs around Australia to meet, chat, eat, and enjoy West Australian wines as well as admire the Perth city skyline.

Other Paediatric nursing invited speakers were Samantha Keogh, Queensland University of Technology and Royal Children's Hospital in Brisbane and Anne-Sylvie Ramelet, Curtin University and Princess Margaret Hospital in Perth. Both speakers are currently PhD candidates and Samantha presented on her development of collaborative guidelines for weaning from

ventilation, whilst Anne-Sylvie spoke about the assessment and management of pain and sedation in infants and preverbal children following cardiac surgery. We were fortunate to have enjoyed the contribution of such a high calibre of speakers at this meeting.

The winner of the best paediatric nursing free paper/ poster was Samantha Keogh for her poster oral presentation entitled "Staff perceptions of the use of guidelines for weaning from mechanical ventilation in the PICU". Congratulations to Samantha.

A special thank you to Anne-Sylvie Ramelet, for all her assistance helping me to organise the paediatric nursing aspects of the 2002 Perth meeting. Thank you also to our conference organisers Eventedge for managing everything behind the scenes.

## Information For Authors

*Pediatric Intensive Care Nursing* welcomes paper submissions for upcoming issues of this publication. Papers may focus on any clinical or professional topic relevant to nursing the critically ill child and pertinent to an international nursing readership. Submissions should be 2-4 double-spaced pages in length.

Send your proposed papers directly to Franco Carnevale (Editor):
frank.carnevale@muhc.mcgill.ca

## Contents of Previous Issue

**Pediatric Intensive Care Nursing**
***Newsletter of the International Pediatric Intensive Care Nursing Network***
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*If you have missed this past issue, as well as any other issue, you can access them at our website: http://groups.yahoo.com/group/PICU-Nurse-International (just click on 'Files')*

## International Nursing Research Network

*Submitted by Beverley Copnell, RN, RSCN, BappSc.*
*Senior Research Assistant, School of Postgraduate Nursing, University of Melbourne, Melbourne, Australia*

As some of you may remember, around two years ago we announced the establishment of a planning group to develop an international paediatric nursing research network. Well, the planning took a little longer than anticipated, for a number of reasons, but the network has now been formally launched. The aims of the IPNRN are to:

1. Enhance the care of children and their families through use of research findings.
2. Raise the profile for research in child health and paediatric nursing.
3. Enhance the conduct of nursing research concerning the health of infants, children and adolescents and their families.
4. Provide a focal point for the sharing of research evidence, experience and expertise for nurses wishing to conduct research concerning the health of children and their families.
5. Facilitate communication between researchers in the field of child health care.
6. Identify areas where research is needed, preventing unnecessary duplication.
7. Foster international research collaboration for research studies concerning child health care.

A discussion group and a website have been established as the first stage in working towards these aims. Check out the site and join the group at
http://groups.yahoo.com/group/PaediatricNursingResearchNetwork/

## World Federation of Critical Care Nurses

Dear friends and colleagues,

Please note in your diary that the World Federation of Critical Care Nurses will have a full Council of Representatives meeting in San Antonio, Texas USA on May 17-18, 2003.

This will be co-located with the 2003 AACN National Teaching Institute (see AACN - www.aacn.org).

An early agenda of the meeting and associated activities will be forwarded to all member associations of WFCCN, sponsor partners and any interested groups.

If your organisation has not joined WFCCN as yet and you wish to participate in this meeting or receive further information on the WFCCN activities please respond to me directly and I will assist.

Yours sincerely,

Ged Williams
Chair, WFCCN

***World Federation of Critical Care Nurses – Mid year report 2002***

The Core Administration of the World Federation of Critical Care Nurses met in Paris in late May 2002 to participate in the first European Federation of Critical Care Nursing Associations' Conference and to forward the agenda of the WFCCN in related activities.

Highlights from the week of meetings:

1. Participation in the EfCCNa Council meeting. We would like to congratulate EfCCNa on their continued activities and collaboration and the success of their first conference. The opportunity to sit in on the two day Council meeting provided an opportunity to share issues and ideas on the world of critical care nursing.
2. Meeting with International Council of Nurses (ICN) – Tesfamichel Ghebwit (Nursing Policy Officer ICN, Geneva). WFCCN and ICN were able to share and discuss objectives and activities and found a lot of similarity and potential synergy between our two organisations. Further discussions within WFCCN and with ICN will work towards a possible affiliation agreement in 2003.
3. Meetings with Trade representatives interested in WFCCN. Two companies met with WFCCN Core Administration while in Paris to progress joint interests in a partnership that will see expansion of WFCCN activities supported by trade companies. WFCCN has a goal of not charging member associations for their participation in the WFCCN, hence the role of trade in supporting the costs of any new initiatives is vital.
4. Meeting with Editors of CONNECT – Draft contractual arrangements are being finalised that will hopefully see CONNECT become the official journal of the World Federation of Critical Care Nurses. It is hoped that the official journal will be distributed to each member country free of charge by 2003.
5. Website – The Core Administration reviewed its plans and requirements for a WFCCN website. The domain name is now registered and Code Blue Nursing Agency from Australia has agreed to sponsor this development. A proposed developer from within the nursing profession has been identified and will submit detailed plans and costs for the Council to consider. It is hoped the website will be accessible by end 2002.
6. Logo – the draft logos presented were reviewed and narrowed down to one option with recommendations now in place to finalise the WFCCN logo. A banner to capture our mission is yet to be agreed and member organisations will be asked to submit options for the council to consider in 2002 via virtual discussion (ie via email!). The logo will be copyrighted before using formally.
7. Financial management – WFCCN has registered itself as a financial entity in Washington State, USA with Wells Fargo Bank. Sponsorship payments have been entered and regular business transactions are now possible.
8. Linkages – in addition to the discussion with ICN, WFCCN has a strong and collaborative relationship with the World Federation of Societies of Intensive Care and Critical Care Medicine and are exploring ways in which the two organisations can increase their joint activities and support for each other on shared projects. Initial approaches regarding the 9$^{th}$ World Congress on Intensive Care have commenced. WFCCN has also received a favourable response from the American Association of Critical Care Nurses to host the next meeting of the full WFCCN Council in conjunction with the AACN National Teaching Institute in Texas, May 2003. As a new member to WFCCN, AACN will be able to meet and share their knowledge and ideas with members of Council whilst utilising some council members in the NTI proceedings.
9. Future Conference – WFCCN has accepted approaches from member organisations regarding the possibility of hosting the First World Federation of Critical Care Nurses Conference in partnership with one of our member associations by 2004. This is an exciting prospect to help raise the profile of WFCCN but to boost the attraction for one of our member associations to host such an event in their own country.
10. Attached Work activities of WFCCN Council June2002-May 2003.

For further information contact:
Ged Williams (Chair): ged.williams@nt.gov.au, or
Belle Regardo (Secretary): bellerogado@yahoo.com

***WFCCN – Schedule of Activities/Tasks***
***June 2002 – May 2003***

**2002**

**June**

| | |
|---|---|
| - Make final changes to logo, distribute for final comment and confirm | G.Williams |
| - Finalise and sign Agreement with CodeBlue and Abbott Laboratories | G.Williams |
| - Proposal and plan for website development – ask for detailed costing and work schedule from Karl Oyri (Norway) | J.Albarran |
| - Schedule of activities of WFCCN and finalisation of sponsorship arrangements with Datex-Ohmeda – letter to Susanne Kreuter 7 June. | G.Williams |
| - Letter of offer to jointly host and support 9th World Congress in Intensive Care, Argentina 2005 (to WFSICCM) | G.Williams |
| - Letter confirming requirements and activities required by WFCCN at NTI Texas USA in May 2003 (to AACN) | G.Williams |
| - Contract finalisation with *CONNECT* Editors | G.Williams |
| - Confirm appointment process for Assoc Eds and Advisory Board | |
| - Plan for WFCCN distribution from "Winter" 2002 | |
| - Plan for official Launch of Official Journal status, May 2003 | |
| - Confirm registration of business name and banking details for WFCCN | B.Budz |
| - List of current corporate sponsor approaches to John | All |
| - Develop guidelines and requirements of WFCCN first World Conference of Critical Care Nurses, 2004 | G.Williams |

**July**

| | |
|---|---|
| - Finalise logo and motto for WFCCN | B.Rogardo |
| - Apply for and obtain copy right for logo and name | G.Williams |
| - Apply for and obtain rights to domain name www.wfccn | J.Albarran |
| - Confirm website implementation plan and cost with provider | J.Albarran |
| - Draft budget/expense account for WFCCN July-June 2003 | B.Budz |
| - Obtain official letterhead, envelopes, business cards, quote for banner | B.Rogardo |
| - New member association package developed and sent to all associations | B.Rogardo |

**August**

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|---|---|
| - Complete sponsorship package for all Corporate Sponsors | J.Albarran |

**September**

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|---|---|
| - Confirm site/date/details of first World Conference, 2004 | J.Albarran |
| - Interim website available for comment | J.Albarran |
| - Editorial team selected & plans developed for journal | G.Williams |

**November**

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|---|---|
| - Website launched electronically (Official Launch May 2003) | J.Albarran |

**December**

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|---|---|
| - 5 Corporate sponsors signed and paid | J.Albarran |
| - 20 member countries signed, Council delegates identified | B.Rogardo |

**2003**

**February**

- Confirm and distribute WFCCN Council meeting agenda and papers to all member countries B.Rogardo

**May**

- WFCCN Council meeting Texas USA
- Nominate, elect, confirm Core Administration
- Develop and confirm WFCCN strategic plan 3-5 years
- Review and act on world wide critical care education guidelines (ie the Madrid guidelines)
- Launch WFCCN journal and website
- Others confirmed closer to time

## What are your comments?

The Editorial Board would appreciate your comments on this publication. This can include any thoughts that you have regarding the structure as well as the content of the Newsletter. We would particularly appreciate your suggestions on topics or issues that you would like to read about in future editions.

Forward your ideas to Franco Carnevale (Editor) :
frank.carnevale@muhc.mcgill.ca

## Welcome to the *International Pediatric Intensive Care Nursing Network* (IPICNN)

*Franco Carnevale, RN, PhD*
*Moderator, PICU-Nurse-International*
*Montreal, Canada*

Note: Article on PICU-Nurse-International published in *CONNECT: Critical Care Nursing in Europe*, 2001, Vol.1, No.4, p.139.

It is my pleasure to introduce you to the *International Pediatric Intensive Care Nursing Network* (IPICNN). IPICNN is a semi-formal organization of nurses interested in pediatric intensive care. It was formed in 1996 in Rotterdam, The Netherlands, during the 2nd World Congress on Pediatric Intensive Care. IPICNN was created by its 3 coordinators: Wil de Groot-Bolluijt (The Netherlands), Patricia Moloney-Harmon (Unites States), and Franco Carnevale (Canada). These 3 coordinators are also the nursing representatives on the Board of the *World Federation of Pediatric Intensive and Critical Care Societies*.

IPICNN was formed to foster communication and collaboration among pediatric intensive care nurses around the world. In June 2000, an Internet discussion egroup was created to enable this group to dialogue easily. This egroup is the principal manner for nurses to become members and participate in IPICNN. It is called PICU-Nurse-International. Of course, nurses without Internet facilities can also become a member of IPICNN without joining our egroup (we arrange to send our publications to them by regular mail).

IPICNN currently has over 300 members from over 25 countries, representing every continent (except Antarctica of course). Members of IPICNN engage in a wide range of discussions through this egroup addressing numerous clinical, educational, professional, administrative, and research issues. The group's international perspective is truly remarkable.

IPICNN also created an official newsletter in 2000 called *Pediatric Intensive Care Nursing*. This Newsletter has been published twice a year, but is now moving toward 3 publications per year. The Newsletter is managed by an International Editorial Advisory Board that represents 12 countries. It contains several articles from different regions of the world. It also presents some of the more remarkable discussions that have taken place within the egroup.

Our Newsletter is accessible to everyone (even non-members) through IPICNN's website (at http://groups.yahoo.com/group/PICU-Nurse-International). Simply click on 'Files.' We welcome the 're-publication' of our articles in the newsletters of other groups, as long as we are cited as the original source (see specifications in our Newsletter). So, if you are looking for good international articles for YOUR newsletter – come visit us!

Our website also provides several interesting website links (simply click on 'Bookmarks'). There are many very interesting international links.

Anyone interested in more information, or in joining IPICNN or our egroup PICU-Nurse-International (it's free!), contact Franco Carnevale (frank.carnevale@muhc.mcgill.ca).

## 4th World Congress on Pediatric Intensive Care

*Hynes Convention Center*
*Boston, Massachusetts, USA*
*June 8 – 12, 2003*
www.pic2003.com

Dear Colleagues,

By now you all should have received the 2nd announcement for the 4th World Congress in Pediatric Critical Care to be held in Boston USA from June 8-12, 2003. As Co-Chair of the Scientific Committee, I would like to personally invite you to attend and also remind you of the January 15, 2003 abstract deadline. Updates can be found on the website http://www.pic2003.com.

Although I would have loved to go to Argentina, Boston is a great place to live and visit. Great venue - please consider staying in one of Boston's great Bed and Breakfasts. [see http://www.boston-bedandbreakfast.com]

The meeting -
We start with 3 preconferences: State of the Art Pediatric
Cardiovascular ICU Nursing, Evidenced Based Pediatric Critical Care
Practice, and a Workshop on Cardiac ECMO.
Nursing topics and speakers are integrated throughout the rest of the 4-day program. You'll find an "Advances in Nursing Science" breakout session within each body system track while nurses are taking the lead in the Therapeutic Milieu, Pain & Comfort, Quality Management and Ethics tracts.

Meet the Expert sessions (How I do ..... ) are still in development. If you have a specific speaker request here please let me know and I'd be happy to try to set it up.

Professional issues will be covered in the program but will be presented by oral abstract presentations in the following areas: (1) advanced practice nursing, (2) care delivery models, (3) education models, (4) leadership models, (5) recruitment and retention, & (6) organizational management. The best 4-5 submitted abstracts will be clustered in one session with an international expert invited to chair/comment. This way we'll hopefully get the best work presented by the individual's doing the work.

ABSTRACT DEADLINE IS JANUARY 15, 2003 ... so there is a ton of time to create or crunch any data you have to support any/all of the abstracts so that they'll be data-based.

We would also like to invite nurses to submit abstracts on "Challenging Cases" in which nursing/nurses made a novel / unique contribution. The format of the presentation would be case study with lessons learned (patient presentation, past history, current problem/issue, how resolved/managed, what was learned).

The best part of attending an international meeting is the diversity of thinking that is always personally and professional stimulating. Please let me know of your questions/concerns.

Regards,

Martha Curley, RN, PhD, FAAN
Critical Care and Cardiovascular Nursing
Children's Hospital Boston


News from WFPICCS:

The *4th World Congress on Pediatric Intensive Care* will be held in the Hynes Convention Center in Boston USA, June 8-12, 2003.
The board of WFPICCS is grateful to the local organizers and the scientific program committee to organize this congress on such a short term. The scientific program under the leadership of Martha Curley and Jerry Zimmerman have done a great job! Most of the invited speakers have accepted the invitation resulting in a fascinating scientific program with a high quality. The model of track lines developed by internationally recognized has been proven useful in Montreal and will be used again in this Congress. There is a balance between integrated nursing and medical session and independent nursing and medical sessions. Pre-Congress activities will be held on the Saturday/Sunday prior to the opening ceremony. The American Academy of Pediatrics (AAP), SLACIP (Paediatric i.c. society from Latin America) and GFRUP (French speaking paediatric intensivists) will have Pre-Congress scientific programs. The cultural program is still under development but looks very promising with typical New England aspects. There will be a possibility to visit the typical Harvard medical facilities from past to present. Bob Truog, chairman of the congress, did an excellent job in putting the pieces together for what will be an excellent event.

**Deadlines:**
Abstracts are due for January 15th 2003.
Early bird fees(received for January 15):
Delegate: $495 Resident/RT/Nurse: $150!!! Acc. Person: $100
Regular fees(received for March 31):
Delegate: $595 Resident/RT/Nurse: $295 Acc. Person: $100
Late fees(received after April 1)
Delegate: $695Resident/RT/Nurse: $350 Acc. Person: $100
$=US dollars
Registration is possible either by form or through
www.pic2003.com.

Further information:
EIMP Inc.
759 Square Victoria Suite 300
Montreal, Quebec, Canada H2Y 2J7
Tel:514 2860855
Fax:514 2887945
Email:pic2003@eventsintl.com
In Boston Geneva 2007 will take the opportunity to introduce the next World Congress which really will be become an European event.
Special attention: **DEADLINE EARLY BIRD RESPONSE JANUARY 15th 2003**.

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## Upcoming Conferences

**XXI Congress of the Société Française des Infirmiers en Soins Intensifs**
Adult and Pediatric Intensive Care
Themes: Cardiovascular arrest, Burns, Enteral nutrition, Ethics.
January, 2003, Paris, France
Language: French
Info: www.sfisi.assoc.fr or info@sfisi.asso.fr

**13. Internationales Symposium für Intensivmedizin und Intensivpflege**
Bremen, Germany, February 19- 21, 2003
Info.: Medicongress
Tel.: +49 421 168 900
Fax.: +49 421 168 9020
Email: medicongress@hospital-abc.de
www.intensivmed.de/contents/home.html

**WIT 2003 – 21. Wiener IntensivmedizinischeTage**
Vienna, Austria, February 27 - March 1, 2003
Info.: Kuoni Congress Vienna
WIT 2003
Währinger Gürtel 2 –4/40
A 1090 Wien
Tel.: +43 1 319 76 900
Fax.: +43 1 319 1180
Email: wit2003@kuoni.ch

**6th European Postgraduate Course in Paediatric and Neonatal Intensive Care**
Bern, Switzerland, March 27-29, 2003
Info: BBS Congress GmbH, Barbara Bühlmann
P.O.Box,
CH 3000 Bern 25
Tel: +41 31 331 82 75
Fax.: +41 31 332 98 79
Email: barbara.buehlmann@bbscongress.ch
www.bbscongress.ch

**HAI 2003 – der Hauptstadtkongress für Anästhesiologie und Intensivmedizin und Pflege**
Berlin, Germany, June 19 – 21, 2002
Info: Charité Campus Mitte
Frau S. Unger
Schumannstr. 20/21
10117 Berlin
Tel.: +49 30 450 531 042
Fax.: +49 30 450 531 900
Email: secretariat@hai2003.de
www.hai2003.de

**29th Annual Meeting ‚Gesellschaft für Neonatologie und Pädiatrische Intensivmedizin' – GNPI**
Köln, Germany, July 3 – 5, 2003
Info: m:con
Daniel Ruckriegel
Rosengartenplatz 2
D 68161 Mannheim
Tel.: +49 621 4106 137
Fax.: +49 621 4106 207
Email: daniela.ruckriegel@mcon-mannheim.de

**3rd Annual Spring Meeting European Cardiovascular Nursing Group**
Stockholm, Sweden, April 11 –12, 2003
Info: Conference Secretariat
Tel.: +46 854 65 1500
Fax.: +46 854 65 1599
Email: stocon@stocon.se
www.escardio.org

**10th European Burns Association Congress**
10-13 September 2003, Bergen, Norway
info: eba2003@congrex.no
Website to be announced
Main topics:
Burns in developing countries
Reconstructive surgery
Quality of life
Burn related research

The following **IPOKRaTES** events will be available on the internet at www.ipokrates.info and are mailed on request.

- Mechanical Ventilation in Newborn Infants, Munich, Germany, Jan 29-Febr 1, 2003
- Introductory Course Molecular Genetics, Rust /Vienna, Austria, May 22-24, 2003
- Paediatric Echocardiography, Athens , Greece, May 15-17, 2003
- Curriculum of Excellence in Neonatology: NeoNeuro, Mainz, Germany, May 26-28, 2003
- Neonatal Comfort and Care, Padua, Italy, June 8-11, 2003
- Curriculum of Excellence in Neonatology: Respiratory Disorders, Paris, June 16-20, 2003
- Paediatric and Neonatal Intensive Care, Lecco/Milan, Italy, June 23-25, 2003
- High Frequency Ventilation, Sopron, Hungary May 26-28, 2003
- Neonatal Imaging, Cracow, Poland, Sept 25- 27, 2003