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Guest Editorial
Critical Care Nursing: A World Wide Perspective

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Introduction

In October 2001 at the 8th World Congress of Intensive Care and Critical Care Medicine in Sydney, Australia a meeting was held in one of the conference halls. Present were about 70 critical care nurses from 15 countries who had gathered to consider the benefits of an international network of critical care nurses through their representative national associations or as individuals.

Presentations followed from members of the European Federation of Critical Care Nursing Associations (EfCCNa) who had formed 2 years earlier. A presentation from Belle Rogado of the Philippines summarised the developments of critical care nursing in Asia. Ged Williams from Australia presented the results of his survey of critical care nursing organisations and their members from 24 different organisations/ countries. (1) Others in the audience expressed their own perspective on critical care nursing from many different countries of the world.

By the end of the four-hour meeting, a draft constitution had been formed and approved by the group. (Table 1) The World Federation of Critical Care Nurses (WFCCN) was born! Eight national associations of critical care nurses had agreed to join together to establish the first Council of the WFCCN and had provided representatives to manage the Council and 4 of the new council members were nominated and elected by the audience to form the inaugural Core administration – Chair, Secretary, Treasurer and Trade Liaison. (Figure 1)

Table 1 – WFCCN Constitution: Philosophy, Purpose and Objectives

Philosophy:

The philosophy of the WFCCN is to assist critical care nursing associations and nurses regardless of age, gender, nation, colour, religious beliefs or social background in the pursuit of the objectives of the WFCCN.

Purpose:

The purpose of the WFCCN is to link critical care nursing associations and nurses throughout the world, to strengthen the influence and contribution of critical care nurses to health care globally and to be a collective voice and advocate for critical care nurses and patients at an International level.

Objectives:

- (1) To represent critical care nurses and critical care nursing at an International level.
- (2) To improve the standard of care provided to critically ill patients and their families throughout the countries of the world.
- (3) To advance the art and science of critical care nursing in all countries throughout the world.
- (4) To promote cooperation, collaboration and support for critical care nursing organisations and individuals.
- (5) To improve the recognition given to critical care nursing throughout the world.
- (6) To maintain and improve effective cooperation between all health professionals, institutions, agencies and charities who have a professional interest in the care of critically ill patients.
- (7) To establish standards for education, practice and management of critical care nursing.
- (8) To foster and support research initiatives that advance critical care nursing and patient/family care.
- (9) To encourage and enhance education programs in critical care nursing throughout the world.
- (10) To provide conferences, written information and continuing education for critical care nurses.



Figure 1: WFCCN Core administration

Table 2: History of formal International Dialogue aimed at forming stronger international networks between critical care nurses and CCNOs.

1985 - 4th World Congress - Tel Aviv – Australian Critical Care Nurses first ask to be admitted to WFSICCM.
 1989 - 5th World Congress - Kyoto - Australia and USA applications accepted by WFSICCM. Sarah Sandford (USA) and Lorraine Ferguson (Australia) ask for nursing position on the board.
 1993 - 6th World Congress - Madrid - CCNOs from Australia, USA, Britain and Spain formally admitted to WFSICCM and Nursing member appointed to board (Belinda Atkinson, England). Madrid Declaration on the Preparation of Critical Care Nurses announced and signed. CCNOs pledge to improve international communication, collaboration and expansion.
 1994 - AACN Global Connections Conference, Toronto. CCNO's meet during this conference, share visions and pledge to improve international communication, collaboration and expansion.
 1997 - 7th World Congress - Ottawa - CCNOs meet during this conference, share visions and pledge to improve international communication, collaboration and expansion.
 2000 - BACCN - Global Connections Conference, Edinburgh. Ged Williams presents results of the world CCNOs survey and outlines possibilities for a World Federation of Critical Care Nursing Organisations.

Key:

AACN: American Association of Critical Care Nurses

BACCN: British Association of Critical Care Nurses

CCNO: Critical Care Nursing Organisation

WFSICCM: World Federation of Intensive Care and Critical Care Medicine

For many years previous to the 8th World Congress critical care nurses had met to discuss the possible formation of a worldwide network, but it was not until 2001 that this goal was finally achieved (Table 2).

What did critical care nursing organisations want at an international level?

The worldwide study of critical care nursing organisations and their activities (1) sought to find out how many such organisations of critical care nurses existed in the world. In order to find critical care nursing representatives, word-of-mouth and loose networks of individuals was by far the most successful form of finding and communicating with key persons who wanted to help with the original study. Eventually a representative sample of critical care nursing associations (and /or individual critical care nurses in countries with out critical care nursing associations) were identified to help inform the key issues and activities of critical care nurses in those countries represented in the study.

Twenty four surveys were completed and returned (Table 3).

Issues important to critical care nurses of the world: When asked to identify the issues that were currently important to them, almost every country identified inadequate staffing levels as being the most important issue for critical care nurses (Table 4). Other important issues included working conditions, access to quality educational programs and wages.

Table 3: Countries responding to survey (number of members in society).

<u>Americas</u>	<u>Europe & Africa</u>	<u>Asia & South Pacific</u>
Canada (1200)	Iceland(75)	Slovenia(300)
USA (65,000)	Britain(3200)	Greece (115)
Mexico (200)	Norway (1700)	Germany(850)
	Belgium (450)	Denmark (2700)
	Italy (2500)	Ireland(400)
	India (N/A)	France (225)
	Turkey (300)	Finland (1456)
		Korea(2000)
		Hong Kong(500)
		Australia (2500)
		Taiwan (N/A)
		New Zealand(130)
		Japan (1300)
		Phillipines (350)

Services and supports provided by critical care nursing organisations to their members: The respondents perceived professional representation, national conferences and standards for educational courses as the three most important activities provided for critical care nurses by their national association. Interestingly the provision of research funding grants, a website and industrial/union representation were ranked very low against the other options in this question. (Table 5)

Participation in an International Society (Network) of Critical Care Nursing Organisations (CCNOs): Respondents identified several activities they perceived such an international society could provide. These activities were then grouped into the categories of practice, education, research and professional. Practice activities included exchange of information, staff exchange programs and benchmarking practices. Educational activities encompassed study tours and sharing educational programs and ideas. The research related activity named was facilitating the conduct of international research. Professional activities comprised the bulk of the suggestions, and included gaining access to conference speakers, worldwide conferences, development of international standards that would inform practice.

When asked what activities and services an international society of CCNOs might offer member associations and critical care nurses internationally, most suggested a website, international conferences and study exchanges as being of most value, providing international education and research support and a journal were also seen as being of value (Table 6).

Table 4: Mean Responses for important Issues for Critical Care Nurses.

^a Issue	World (Mean)
Staffing levels	9.24
Working conditions	8.86
Access to quality educational programs	8.76
Wages	8.52
Formal practice guidelines/competences	8.38
Work activities/roles	8.33
Teamwork	8.29
Extended/advanced practice	7.90
Relationships with doctors	7.76
Formal credentialing processes	7.60
Use of technologies	7.38
Facilities and equipment	7.24
Relationships with other nursing orgs.	6.90
Relationship with other health groups	6.76

^ascale: 1 = not important; 10 = very important

Table 5: Services/activities provided by Critical Care National Organisation and importance attached to each service/activity

^a Service or Activity	Provided	World (Mean)
Professional representation	17 (71%)	8.75
National Conferences	19 (79%)	8.67
Standards for educational courses	13 (54%)	8.67
Practice standards/guidelines	16 (67%)	8.40
Workshops/Education forums	18 (75%)	8.29
Credentiailling process	12 (50%)	8.25
Journal	16 (67%)	7.93
Local Conferences	17 (71%)	7.81
Newsletter	16 (67%)	7.73
Initiate, conduct or lead research studies	13 (54%)	7.58
Training/Skill acquisition course (eg. Advanced life support)	13 (54%)	7.42
Study/education grants	9 (38%)	7.00
Industrial/union representation	6 (25%)	7.20
Website	15 (63%)	6.79
Research grants	7 (29%)	6.43

^ascale: 1 = not important; 10 = very important)

Nineteen of the 24 respondents suggested English as the first language of choice for international communication. When asked the extent to which they could financially contribute to the administration and communication functions of an international society, only fifteen indicated that they could provide up to \$200 (US) per annum in financial support, seven indicated they could provide in excess of \$750 (US) per annum. The WFCCN has had a policy of NOT charging membership fees for member organisations.

Establishing the World Federation of Critical Care Nurses

As mentioned in the introduction, the WFCCN had only 8 original member countries and no money! The first Council met the day after inauguration to set a plan for the future.

The immediate goals of the WFCCN were set at this meeting, they were:

- To promote the existence of the WFCCN to potential member associations and encourage application and membership.
- The identification of an official journal of the WFCCN to be distributed to all member associations and their members.
- Develop a website of relevant information that is easily accessible to critical care nurses the world over.
- To explore long term legal, financial and constitutional arrangements that will best serve the purposes and objectives of the WFCCN and its member associations.

Table 6: Importance of potential services/activities for an International Society of CCNOs

^a Service and Activity	World (Mean)
Website	9.19
Coordinate/Support in international conference	8.90
Coordinate/Support international study exchanges	8.86
Provide international guidelines/principles relevant to critical care practice	8.74
Coordinate/Support international education	8.67
Coordinate/Support international research projects	8.57
Journal	8.52
Make representation to national and international bodies on issues of health, human-society	8.43
Newsletter	7.48

^ascale: 1 = not important; 10 = very important

Achievements of the WFCCN (As at August 2005)

In less than 4 years, the WFCCN can summarize its activities and achievements:

- Twenty-seven member organisations (Table 7)
- Three corporate sponsors: CodeBlue Nursing Agency (Australia), Abbot Laboratories/Hospira, Datex Ohmeda.
- Establishment of a website: www.wfccn.org
- Establishment of an online journal *CONNECT The World of Critical Care Nursing*: www.wfccn.org/Pages/journal published quarterly.
- Annual national conference run in conjunction with member or affiliate societies – 2004 (Cambridge UK, with BACCN), 2005 (Argentina with WFSICCM), 2006 (Manila, Philippines with CCNAPI), 2007 (Sun City, South Africa with CCSSA), 2008 (to be confirmed), 2009 (Florence, Italy. 10th World Congress with WFSICCM). Our aim is to host a conference at a different part of the world each year.
- Admission to the International Council of Nursing and official participation in the 23rd Quadrennial meeting of ICN in Taiwan, May 2005.
- Development of two key Position Statements:
 - Provision of Critical Care Nursing Education
 - Provision of Critical Care Nursing Workforce
- Strategic linkages and support to the emergence and growth of regional critical care nursing federations in: Europe (EfCCNa), Asia-Pacific (APFCCN), Pan American Federation of Critical Care Nurses (to be launched in Venezuela in October 2006 – this will be a Spanish speaking federation), African Federation of Critical Care Nurses (to be discussed and planned in South Africa in 2007)
- Ongoing and healthy relationship with WFSICCM – Joint meeting of both Councils occurred 30 August 2005 in Argentina and a commitment to ongoing meetings and activities made at the meeting (See figure 2).
- Worldwide study of critical care nursing in progress – expected publication in 2006. This study is similar to that discussed earlier. (1) – 49 countries have participated.



Figure 2: Joint meeting of Councils of WFCCN and WFSICCM (August 30, 2005, Argentina)

Table 7: Members of WFCCN as at August 2005

Core Administration:

President - Ma. Isabelita Rogado (Phillipines)
 Secretary - Shelley Schmollgruber (South Africa)
 Treasurer - Bernice Budz (Canada)
 Trade Liaison- Gerardo Jasso Ortega (Mexico)

Members

Argentina* – Laura Alberto
 Australia – Denise Harris
 Brazil – Denis Moura Jr
 Chile - Celia Ortiz
 China - Liu Shuyuan
 Cyprus - Evanthia Georgiou
 Denmark - Birte Baktoft
 Hong Kong - Esther Wong
 Iceland - Rosa Thorsteinsdottir
 Japan - Yuko Ikematsu
 Kingdom of Saudi Arabia* – Mark Fielding
 Netherlands - Wouter. de Graaf
 New Zealand - Gordon Speed
 Norway - Lisbet Grenager
 Peru – Rossana Gonzales de la Cruz
 Slovenia - Slavica Klancar
 Spain - JeronimoRomero-Nieva Lozano
 South Korea - Dong Oak Debbie Kim
 Sweden - Monica Magnusson
 Taiwan - Yolanda Huang
 United Kingdom - John Albarran
 United States of America – Justine Medina
 Venezuela – Raiza Rada

** Individual member (country does not have a critical care nursing organisation yet)*

Creating a sustainable future for critical care nursing worldwide

From humble beginnings, the world of critical care nurses and the WFCCN are demonstrating the capacity to communicate effectively across various language, cultural and geographical barriers; to get organised; and to generate resources to support mutually agreed activities and goals. The WFCCN provides a legitimate forum for the expression of a collective opinion of what the world of critical care nurses believe to be important issues and activities to improve the effectiveness of critical care nursing, furthermore and more importantly, the WFCCN is an advocacy body for representing the needs of critically ill patients and their families – arguably some of the most vulnerable people in our communities. This role and responsibility cannot be managed alone for it is too great for one group to shoulder.

The WFCCN recognises the important base from which we are supported and the important strategic advantages of working collaboratively with those groups who share a similar philosophy and mission. Our roots stem from well educated but pragmatic clinical nurses who provide 24 hour a day seven day a week care to the critical ill in every part of the world. These nurses meet and discuss issues, ideas and solutions, they get organised in their hospitals and share these ideas with their jurisdictional and national organisations. The national organisations of critical care nurses contain sophisticated and politically astute leaders who work with other national bodies and governments to analyse the issues presented to them, to mobilise resources and action to address the concerns and ultimately improve the quality of care afforded the critically ill. At an international level the WFCCN bring together the collective issues, where ideas and experiences of our member associations can be shared across geographic, cultural, linguistic and political boundaries so that nurses can learn from one another, help one another and ensure that the care of their patients is forever improving. Furthermore WFCCN establishes strategic alliances with WFSICCM, WFPICS, ICN, World Health Organisation and others over time to ensure the needs of critical care nurses, patients and their families are acknowledged in the appropriate policy making forums of the world.

The future looks bright...

It is foreseeable that in the next 4-5 years, research into clinical and humanitarian issues will emerge as priorities. Linking stronger member societies to emerging societies in developing countries will see the strengthening and equalization of standards of care internationally. Sharing of knowledge, ideas and resources (financial, intellectual and human) at an international level, no matter how meagre to start with, will create a culture of goodwill and ultimate improvement in our specialty.

This is a utopian end to an otherwise pragmatic and tough reality. The formative years of the WFCCN have been quiet but notable, the path is now laid for a more productive and effective future.

Reference

(1) Williams G, Chaboyer W, Thorsteinsdottir R, Fulbrook P, Shelton C, Chan D, Wojner A. 2001. World Wide Overview of Critical Care Nursing Organisations and their Activities. *International Nursing Review*. 48, Dec: 208-217.

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Hurricane Wilma during the 7th Latin American Congress in Pediatric Intensive Care in Cancun: Seven Lessons to Learn

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It was to be a great event for Latin-American Pediatric Intensive Care.

October 19th 2005 at 7:30 am the scientific activities of the 7th Latin American Congress on Pediatric Intensive Care began as planned. All happened as intended on the first day of the scientific activities. But ... we all knew that hurricane Wilma was around the corner...

As invited speakers, we were set and excited to share our experience in pediatric intensive care, to have a great event and to have a wonderful time in the paradisiacal city of Cancun, in Mexico.

In the afternoon around 5:30, before the dinner congress party, we were informed that the event was cancelled because Wilma was coming (announced as one of the largest tropical storms ever seen).

Despite the anxiety-provoking news, the hotel staff and other guests were so calm - we could not have realized what was going to happen. We got official written information with plans A to D from the hotel management concerning what to do step by step every couple of hours. The dinner took place at the hotel's restaurant and most of us enjoyed this time with most of the congress faculty members but some of the registrants were fearful and trying to get a flight out as soon as possible.

First lesson to learn: never underestimate this kind of natural phenomena but don't lose your cool mind and ability to think.

At midnight we were awakened by some of our Mexican friends and organizers of the congress, telling us about the need to make a decision for the next few hours: to leave the hotel, on our own, out of the city by bus to a relatively unknown destination or to stay under the supervision of the hotel staff accepting the plan of the local experts. Some of our colleagues decided to go, while others stayed.

Second lesson to learn: do not make important decisions with insufficient information. If you have any doubts, try to solve it with as much information as you can get. Try to analyze what is a controlled risk.

Some of those who decided to stay recognized (few days later in the shelter, when we talked about it and analyzed our decision) that they were fascinated with the opportunity "to live" a hurricane and observe the organization of the local agents.

The next day (October 20th) we were informed that the evacuation process would be started at 10:00 am and that we would probably stay for one day in the shelter. At this time we

were aware that most of the congress faculty had left by bus. At this moment we, the few who stood there, structured ourselves as a group to support each other from this instant until the minute we left the Mexican ground, many days later.

Third lesson to learn: look to see who is around you in an emergency situation and try to make the best of it. Organize the group and prepare yourself for a longer and worse time than you are expecting to live. Nothing gives you more sense of being safe in this sort of situation than to be part of a team - it supports and comforts you.

We and the others, approximately 300 people (hotel staff, unknown guests, congress attendants and faculty) were carried by buses to the shelter, a university, one hour away from the hotel and shore's zone. Each of us received a pillow, towels, some food and bottles of water. Suddenly we could see some people with eight or ten of each article. On the other side, someone kept one or two of each item as requested by the hotel staff.

Fourth lesson to learn: the fear of death and self- preservation instincts makes human beings do things that they have never ever done in other situations. Control has to be strong to permit equal access to the goods for all.

Wilma arrived around 2:00 am October 21st. The intensity of the wind was up to 290 km/hour and the destruction because of this power gradually increased to an indescribable degree. The range of reactions to this phenomenon was wide: mostly silent, some stood quiet, some were aggressive while others cried; nobody could play with the games the organizers gave us. We knew that human fear smells bad. The common interest was trying to communicate outside with our families. Some Mexican nurses that were in our room began to tell jokes and laugh loudly. These behaviors were badly tolerated in the first 24 hours but well accepted later, relaxing the others.

Fifth lesson to learn: do not judge human feelings by human behaviors merely; each one of us has different ways to cope with stress. Try to identify and support the weakest early on because of the danger of hysterical reactions.

Is it important to highlight the significance of the ability to laugh and maintain a sense of humor in adversity. It helps to deal with fear and stress. But not all people understand this. Be aware of that.

No one could ever imagine that Wilma would be so powerful and destructive, and at the same time so slow, crossing through Cancun at a speed of 5 - 10 km/h. This last factor was less easy to tolerate than the force of the wind itself. We stood 4 days in a wet, uncomfortable, hostile, noisy, and progressively destroyed environment without electrical light, water and enough food.

The fear of loosing our lives was constant, although, despite being familiar with death, as all healthcare professionals are, nobody talked about it. However, the hotel staff had to deal with other feelings, such as not knowing what was happening with their beloved ones, their homes, their friends and personal belongings so close and at the same time so distant from them. The responsibility, accountability, and extraordinary professional behavior were constant throughout the period that we were together in the shelter. They worked very hard, without rest, demonstrating great emotional strength.

Sixth lesson to learn: The sense of being part of a team, with well established goals and actions, being "orchestrated" with accuracy by leaders, developed in the group a strong sense of duty that allowed them to overcome their own fear and stress.

On October 22nd Wilma left Cancun and the relief and joy could be felt and seen in each of us. But a new danger was coming in: people from the town were vandalizing the supermarkets. The manager of the hotel directed us to the new buses that were coming for us from Merida. They had no food or water for the 300 people and the risk of infections was rising. We had to leave!

The disaster outside delayed the arrival of the buses taking 12 hours for 200 kms. The hotel manager had to make one of the most important decisions: send us by bus to another city, during the night, with tired bus drivers or leave us in the shelter one more night, with the known risks. He decided we should go.

The roadways were as bad as the hurricane! The roads in Cancun and on the way to Merida were under water. There was no light. Sometimes the bus lights were submersed in the water and the drivers could only use their memory of the streets. Many of us came to the front of the bus with our cellular phones on. On the way we saw broken buildings, trees, traffic signs,

electric cables and dozens of submersed cars. The destruction was everywhere and in everything. Many times we had to leave the buses and walk through the darkness of the tropical forest. For many of us, this travel was a moment of a truly huge fright.

Seventh lesson: don't leave a relatively sure shelter if you can soon expect a cutoff in the dangerous situation. At the end of a natural disaster there are other hazards, such as, collisions, electrocutions, diseases, hunger and thirst. The exhaustion can make you take a wrong decision!

These were some moments of our experience to demonstrate the weakness and extraordinary strengths of human beings dealing with natural catastrophes. Despite having to admit that we had one of the worst moments of our lives, we also learned a lot about the intrinsic and natural kindness, gentleness, empathy, friendship, solidarity and compassion of human beings.

We hope that the Mexican people can recover completely from this disaster and deal with the others that are coming, being as prepared as for this one, and that Cancun, that colorful, beautiful and paradisiacal city, can be reconstructed as soon as possible.

Come & Join PICU-Nurse-International

An Internet discussion group of the
International Pediatric Intensive Care
Nursing Network.

For more information, visit our website:
[http://groups.yahoo.com/group/PICU-Nurse-
International](http://groups.yahoo.com/group/PICU-Nurse-International)
or contact Franco Carnevale (moderator) at
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Research Paper

To keep alive or let die **Parental Experiences with Ventilatory Decisions for their Critically Ill Children**

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Abstract

This article reports selected findings from a larger study examining the moral experience of families with children requiring long-term mechanical ventilation at home. The data presented here refer directly to families' experiences in critical care settings where they are faced with the decision of bringing their child home with a respirator and other related therapies. The data presented here are drawn from 18 parents (from 12 families) recruited through the Home Ventilatory Assistance Program of the McGill University Health Centre in Quebec, Canada. Data were collected through interviews and observations, all conducted in the families' homes. Two principal themes emerged. First, parents struggled with negative staff attitudes. They repeatedly faced what they perceived as pessimistic and discouraging words and actions from staff, from which parents inferred that staff attributed little worth to the lives of their critically ill children. Second, parents had to deal with difficult choices. Parents were very distressed by having to decide whether or not to keep their child alive. They frequently felt like they did not really have a free choice. The article concludes with recommendations that treating teams working with this population critically examine their approaches, in light of this evidence, and seek to reconcile the difficulties raised by these parents.

Introduction

In this article, we report findings from a larger study examining the moral experience of families with children requiring long-term mechanical ventilation at home. The data that we present here refer directly to families' experiences in critical care settings where they are faced with the decision of bringing their child home with a respirator and other related therapies: namely, pediatric and neonatal intensive care units. Our broader findings highlight a wide range of additional themes relating to significant community attitudes and barriers. These will soon be published (Carnevale et al., 2006). For additional research findings with this population see Alexander et al. (2002) and Earle et al. (in press).

Thirty-eight family members (from 12 families) participated in this study, including the ventilator-assisted children, their parents and siblings. The data we present here are drawn from the 18 parents in the study. Families were recruited through the Home Ventilatory Assistance Program of the McGill University Health Centre in Quebec, Canada.

Ventilator-assisted children in the study ranged in age from 1.8 to 19 years of age. Diagnoses contributing to their ventilatory dependence included central hypoventilation syndrome, muscular dystrophy, spina bifida, obstructive apnea, spinal amyotrophy and various myopathies. Approximately half of the children used invasive ventilation, via a tracheostomy while the other half used noninvasive (i.e., mask) ventilation.

We examined family moral experiences through interviews and home visit observations. The entire study was conducted in the homes of these families. It should be noted that the family experiences described below do not necessarily refer to our own hospital setting, as most families were referred from other health centers.

Findings

The principal theme that best characterized these families' experiences was referred to as "daily living with distress and enrichment." These families' lives were clearly very stressful yet they described their lives as generally very rewarding regardless of: (1) the child's specific diagnosis; (2) whether the child required invasive versus non-invasive ventilation; or (3) the level of care required by the child.

These families clearly pointed out that despite the tremendous difficulties encountered, they experienced great enrichment and that they could not imagine life without their child. It would therefore be mistaken to conclude that ventilation should not be an option offered to families because of the stress it causes in their lives.

We outline below themes that emerged relating to the attitude of some critical care staff. We also describe some of the distresses that parents experienced regarding the life support decisions they had to make for their children. It is remarkable that although these families have numerous stresses to manage regarding the child's need for continuous care, families reported that their most significant stress was related to the attitudes and reactions of others toward their child – including health care professionals (HCP). Several direct quotes from parents are presented to help illustrate their experience.

Negative Staff Attitudes

All parents found it difficult to see that their child's life had little worth for some staff. Whereas these parents looked to their children as having unconditionally significant lives, they felt offended by the way some staff questioned ventilatory support –

inferring from staff that everyone would be better off if the child was dead.

The health care professionals told (us) that it did not make sense to keep the child alive.

They told me that long-term ventilation would not be the right thing to do, so I had my child transferred to another hospital that offered me other options.

He was in ICU for 9 days and then the doctor told us that he probably wouldn't survive his next flu. Like that. As bluntly as that – standing in the waiting room.

Some parents spoke of how the fact that their child had Trisomy 21 was announced. One physician said that their newborn was a "mongol". The mother said,

The physician asked us if we were going to keep her or institutionalize her. I felt that just because of her Trisomy 21, I didn't honestly feel, sincerely, much enthusiasm from the doctors toward my daughter. This disappointed me enormously.

Parents reported that some staff strongly urged them not to take their ventilated child home – expressing a very pessimistic outlook for their child.

One doctor told us that it would be better to leave him in the hospital – flatly abandon him in the hospital...He told us it would be a burden, family life would be disturbed, that we could leave him in the hospital and put him up for adoption...There was no question in our minds because it was always us who decided...There was no question about it.

The pediatrician looking after our daughter was very pessimistic. She never stopped talking about the trach. It was all the time "the trach, the trach." It could happen that the equipment might not work. She might need the trach, the trach. We

didn't want the trach. Well, surely if she really needed it, she would have had it, but for us it was: no, no, no and we frequently cried because we didn't want a trach for her.

Difficult choices

Several parents felt thoroughly uncomfortable with being faced with a decision to maintain or withdraw mechanical ventilation for their child. Some parents felt they had no "free" choice – how could they possibly decide to let their child die?

We didn't want to accept it. He (the physician), brought the possibility of being on a ventilator and I had seen the kids at the hospital where they have this big machine in the back of their wheelchair, they had tubes down their throat and it scared me...

I had the choice when she was born to not take her but I mean, we are parents, she was our child and we loved her. We took her. We don't have any regrets having had done it.

They asked me if I wanted to disconnect her, put her up for adoption, or keep her. I said clearly "Well, I want to keep her." They said "Are you serious? You're only 20 years old. You already have a one year old, you're young." I said "Look, it's alright. It's my baby. I'm going to keep her. If her heart stops, let her go." "If her heart would stop, I wouldn't want them to try to resuscitate her like crazy. I said "If her heart stops, let her go." But me, decide to disconnect her and let her die? No. Forget that. That was my decision. I have never regretted it. That doesn't mean that sometimes, times when it gets very, very, very hard, that you don't ask yourself if you made the right choice – but in general I don't.

Some parents were unhappy with how such decisions were discussed by the treating team.

They took us into the little meeting room. They sat in a semi-circle in front of us, the respirologist, the intensive care paediatrician, the respiratory fellow, the psychologist and the nurse taking care of our daughter. They told us, "This is how it is. She will have to be ventilated." But they didn't know yet if she would need a trach or not. So, for us at this point it was very troubling for us. They announced this to us just like that – bang bang. "She will need..." We asked them to leave. We wanted to be alone. Because getting ganged up on, it isn't fun. You're told things like that about your child. It's the little meeting room for bad news. Whenever they take us there, usually it's not a good sign.

Some parents were troubled about how much and when to involve their children with decisions about their care and their life.

I think one of the biggest mistakes we made from the beginning with this whole thing was that we did all the talking for him. We made all the decisions for him. We didn't really give him much choice in anything. And just later, in the last couple of years now we started realizing he's not a baby anymore. He's an adult now and it's time to start letting him make the decision.

Discussion

The findings of this study highlight some of the significant difficulties encountered by parents of children requiring long-term ventilatory support. It is important to recognize that not all staff acted in the ways reported above. In fact, all parents were able to speak of single physicians or nurses that they held in very high regard, because they were attentive to their concerns and treated them and their child with respect and sensitivity.

It is quite possible that in many of the instances reported by the parents above, the HCP involved would describe these events quite differently. Regardless of what may have transpired from the HCP perspective, we consider it critically important to bring attention to the accounts that these parents

have drawn from their experiences. Events unfolded in a manner that caused these parents immense distress and an inherent distrust of the medical system, its HCP and the care provided during repeat outpatient visits and hospitalizations.

We consider it important that HCP working with families of children facing difficult life-support decisions have an opportunity to familiarize themselves with these findings. In fact, we encourage readers to take time to review our larger report (Carnevale et al., 2006).

Life support discussions and decisions in pediatric critical care involve a highly complex process of communication, empathic listening, and skilful guidance that is non-judgmental and unbiased by HCP' personal values and opinions. (Carnevale, 2005). Providing education, training, detailed information regarding care and available community resources also plays a significant role in reducing stress and in preparing the family for the child's discharge to the home. Even in the hands of the most experienced capable clinicians, parents may incur significant distress. Indeed, much of this distress may be inescapable. However, our findings also suggest that careful attention to the relational climate of trust and respect between parents and HCP can significantly minimize the difficulties for everyone involved.

We recommend that treating teams working with this population critically examine their approaches, in light of this evidence, and

seek to reconcile the difficulties raised by these parents. In particular, this population of parents needs guidance and support in determining which life-support decision is the most morally acceptable one for their ventilator-dependent child. Furthermore, HCP need to convey a sense of respect and regard toward the worth of the child's life, regardless of the treatment option they favour. We recognize that many teams are already doing so – providing exemplary service for this very challenging (and growing) population.

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Critical Care Transcending Boundaries: Buenos Aires 2005

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The World Federation of Pediatric Intensive and Critical Care Societies (WFPICCS) integrates different national societies into an international organization. At present all regions of the world are represented through regional and national societies. The latest Board Meeting of WFPICCS was conducted during the 9th Congress of the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM) held from August 27th through 31st in Buenos Aires, Argentina. This was a unique congress because for the first time a joint meeting between WFSICCM, the World Federation of Critical Care Nursing (WFCCN) and WFPICCS was held. This conference attracted and brought together critical care nurses, pediatric intensivists and adult critical care physician colleagues from all around the world. This congress presented a multidisciplinary view of critical care across the lifespan, which contributed to the sharing of new ideas and new perspectives from the different professional groups and different cultures.

The congress was a great success, thanks to the enormous commitment, support and hard work of the South American physicians and nurses organizing the congress. Overall, there were 4500 delegates who attended the congress, of which 478 were pediatric participants from 42 countries. Pediatric Intensive Care was integrated into the scientific program in addition to separate multidisciplinary pediatric sessions. There were 571 abstracts selected for oral or poster presentation during the course of the meeting. Of these presentations, over 100 were pediatric free papers and posters and 30 were specifically related to pediatric

nursing. The timing of the congress was very good as it was the half way mark to the 5th World Congress on Pediatric Critical Care to be held in Geneva in 2007. The timing helped to generate interest and excitement for the future congress in Geneva and reached an audience that may not have been aware of the developments in pediatric critical care, including the upcoming World Congress and the establishment of a journal specific to Pediatric Critical Care Medicine.

The scientific program was of high quality. There was excellent cooperation and sharing of information between the adult and pediatric participants which allowed for a very wide and varied program. There was a robust program of pediatric topics presented. The program included multidisciplinary symposia on: Ethics at the End of Life, Publishing in Pediatric Critical Care Medicine, Pediatric Sepsis and Metabolic Problems, Nutrition in the PICU, Highlights in Critical Care: A world-wide vision, Mechanical ventilation of the pediatric patient, and Quality of Care in the PICU. The nursing scientific program integrated adult and pediatric presentations within tracks including Evidence Based Nursing, End of Life Issues, Patient Safety and Family Centered Care. Family centered care is a very well known entity in pediatrics and is gradually becoming more integrated in adult intensive care units. The pediatric perspective was highlighted in this session with topics focusing on care of the chronically ill child in the PICU and continued care from pediatric intensive care discharge to pediatric unit. This session generated an extensive and in-depth

discussion amongst the pediatric and adult nurses regarding the implementation of family centered care in the intensive care unit.

One session was very special and focused on the World-Wide Overview of Critical Care Nursing Societies, presented from the perspective of various regions. The development of critical care nursing societies in all areas of the world is an ongoing process; the information presented, as well as the opportunity to talk with individuals who are so active in promoting and adding depth to the different societies was both inspiring and humbling. The world of Critical Care came together at this congress. Ged Williams, Chair of WFCCN, which held its inaugural meeting at this congress, suggested that “the meeting in Buenos Aires was the most significant critical care nursing event in history”.

The quality of research that is being conducted in pediatric critical care, particularly in Latin America, was highlighted at this congress during the poster sessions. There were 18 posters presented specific to pediatric nursing. Topics included an action research approach to breastfeeding, neonatal thermal regulation protocol, application of technology and nursing, and concordance between clinical assessment, COMFORT and Ramsay scales, to name a few. This congress provided a very good opportunity for networking with pediatric colleagues and made for an exciting time for facilitating the sharing of scientific knowledge and research in combination with a social program. It enabled participants to exchange knowledge, ideas and goals while making lasting connections which will hopefully foster ongoing personal and professional relationships with future exchanges. It was a privilege to be a part of this Congress and in a small way help contribute to its overwhelming success.

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 2-5 double-spaced pages in length.

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

Spotlight on PICU

This regular column will provide readers with an opportunity to learn about fellow PICUs in various parts of the world.

*Column Editor: Beverley Copnell, RN, RSCN, BappSc, PhD
Postdoctoral Research Fellow, Department of Neonatology, Royal Children's Hospital & Murdoch
Childrens Research Institute, Parkville, Victoria, Australia*

Pediatric Critical Care Nursing in Beautiful British Columbia

*Tracie Northway, RN, MSN, CNCCP(C)
Quality and Safety Leader, Pediatric Critical Care
BC Children's Hospital, Vancouver, BC, Canada*

British Columbia's Children's Hospital is located in Vancouver on the West Coast of British Columbia (BC), Canada. Vancouver is the largest city in the province of BC and the third largest city in Canada. Surrounded by water on three sides, Vancouver nestles alongside the Coast Mountain Range and is home to spectacular natural scenery and a bustling metropolitan core. In addition, Vancouver boasts one of the mildest climates in Canada.



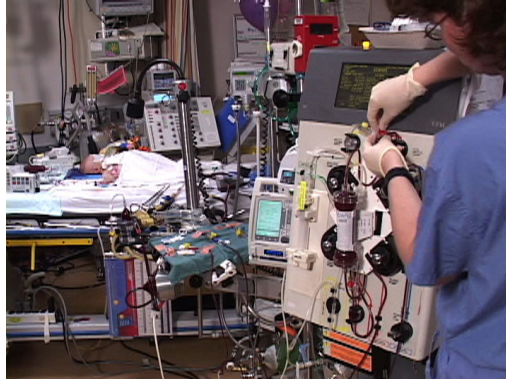
City of Vancouver (2005)

As part of Children's & Women's Health Centre of British Columbia, British Columbia's Children's Hospital (BCCH) is the province's major treatment, teaching and research facility for child health, caring for patients from birth to age 16 years. BCCH is home to many specialized pediatric services available nowhere else in the province.

The Pediatric Critical Care Unit (PCC) is comprised of two care areas housed within one physical space: the Intensive Care Unit (ICU) and the Transitional Care Unit (TCU). The bed capacity of the PCC is 22; 14 beds are designated ICU with the remaining eight allotted for the care of children in the TCU. The number of children admitted annually to TCU and ICU is approximately 1,250. The combined average length of stay between ICU and TCU is 4.5 days. The BC Ambulance Infant Transport Team transports approximately 18% of our patients from communities throughout the province of BC and the Northwest Territories to BCCH ICU/TCU by either air (fixed wing aircraft or helicopter) or ambulance.

The ICU provides intensive care support for critically ill infants, children and adolescents, and close monitoring of high-risk patients in an environment with rapid access to highly specialized nursing and medical support. Intensive care support includes invasive respiratory, cardiac, renal, neurological, nutritional and metabolic support. Sixty percent of our patients are surgical patients (e.g., closed- and open-heart; spinal instrumentation, craniotomies, renal transplants, trauma)

and 40% are non-surgical (e.g., renal failure, burns, neurotrauma, infectious diseases, sepsis, cardiac and/or respiratory compromise/failure). Each year we care for approximately 15 children using extracorporeal life support (ECLS). Forty percent of those children have complete cardiac failure. We boast an “above average” rating from the Extracorporeal Life Support Organization for our ECLS education, procedures and patient outcomes.



Baby following open heart surgery, on extracorporeal life support and continuous renal replacement therapy

Within the past three years, a transitional or stepdown unit has been created to meet the needs of the patient population not quite ready for the general ward areas but well enough to leave the ICU. In addition, the TCU is a care area where patients with complex medical needs (e.g., home ventilation, tracheostomy, complex feeding needs) are prepared for transition into their communities.



Jesse 15 months and his mom, Sylvie

Vancouver is an attractive destination for travelling health care professionals and we have had the distinct pleasure of working with nurses and physicians from many different countries. Staff members newly hired to BCCH ICU or TCU are offered an orientation focusing on pediatric critical care competencies in caring for critically ill and transitioning children. Approximately 100 pediatric critical care educated nurses work in the ICU with experiences ranging from novice to expert. The opportunities for clinical advancement vary based on a nurse’s interest and the patient population. For example, after proving competence, an ICU nurse may assume the role of continuous renal replacement therapy technician, ECLS technician, resuscitation team member, charge nurse, senior resource nurse, or medical emergency team liaison nurse as required. TCU has roughly 18 designated nurses who specialize in caring for the child and family in transition. They excel at working with families of children with complex needs and are noted expert teachers

when it comes to preparing families for discharge. BCCH TCU has been a national leader in the development and support of a provincial home tracheostomy and ventilation program.

Nurses' work schedules are organized through a self-scheduling roster. The hours of work are 12-hour shifts. Usually 14 nurses are scheduled to work any given shift in PCC; however, this varies with patient census and acuity. The nurse: patient ratio is usually 1:1 in the ICU and 1:2 in the TCU. In addition, we have 24-hour resident, fellow and respiratory therapist coverage in the unit. On-call pediatric critical care physician specialists are always within minutes of the hospital.

Our philosophy of care is based upon the principles of family-centred care. A collaborative partnership between staff and families is our goal. Together we seek the essential tools to assist all partners in meeting that goal. Recent adoption of a full-disclosure policy has moved us closer to an ideal model of family-centred care. Full disclosure is simply a means of communicating openly and honestly with patients and their families. It is a term closely associated with medical error management; disclosing an error and admitting responsibility has been demonstrated to improve relationships between staff and families (Mazor et al., 2004). The introduction of the National Medical Error Disclosure and Compensation (MEDiC) Act, in the United States is an example of how full-disclosure legislation is utilized to convince "the medical community to universally adopt a policy of disclosure of medical errors, apologies for these errors and early compensation for patient injury" (Orlovsky, 2005). Within our unit, the use of the term full-disclosure is proactive in an effort to build upon the principles of family centered care by announcing publicly our intent to move towards a transparent partnership with families and children.

Nursing education is supported throughout Children's & Women's Health Centre and especially within the pediatric critical care program. Each nurse is paid for 16 hours per year of continuing education pertinent to his or her work area. The nurse educators prepare two 8-hour education days based on a staff needs assessment in an effort to meet the nurses' education needs on-site. Attendance at these education days is optional, while attending an annual pediatric critical care competency validation day is required. The validation day is designed using an objective structured clinical examination (OSCE) framework. The 1:1 case reviews have been favourably evaluated by the nursing staff as they value the opportunity to demonstrate their knowledge, skill, attitude and judgement in a safe environment. Each nurse is then required to build upon his or her learning plan based on their identified strengths and needs during the validation day. The nurse then shares his or her learning plan with their immediate supervisor as part of their annual performance review.

Nursing research within the PCC has focused on parental presence during procedures, end-of-life decision making, interpreting children's "voices" within PCC, staff satisfaction and leadership and ethics. We have whole-heartedly embraced the patient safety "movement" and have re-energized our active quality assurance team to reflect the international push towards patient safety. We recently marked our one-year anniversary as members of the Canadian ICU Collaborative, an organization of adult and pediatric ICUs aimed at improving critical care through implementation of best practice using a quality improvement framework (Canadian Collaborative, 2005). As a result of our own initiatives, and stealing shamelessly from other pediatric ICUs, we have seen a 61% reduction in our catheter-related bloodstream infections since October of 2004. We have been generously supported by our hospital's Quality, Safety and Risk Management Department through a healthy workplace initiative to fund a partnership with John Hopkins' Patient Safety Group. Through the support of these resources we currently have an interprofessional group of staff members throughout Children's & Women's working on over 20 active projects.

We are looking forward to more changes in the next decade as our unit is anticipating a renovation and implementation of a clinical information system within the next 18 months; we prepare for the hosting of the 2010 Winter Olympics; and we plan for the building of a new children's hospital. We are excited about these known and unknown changes and welcome nurses to join our international team.

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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

Research News

RANDOMISED TRIALS IN CHILD HEALTH IN DEVELOPING COUNTRIES
(3rd Edition)
July 2004-June 2005

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Dr. Trevor Duke has prepared this booklet which is compiled annually to summarize the evidence on child health derived from randomized trials in developing countries over the previous year. The aim is to make this information widely available to paediatricians, nurses, other health workers and administrators in resource poor settings where up-to-date information is hard to find. It is hoped that such information will be helpful in reviewing treatment policies, clinical practice and public health strategies. In most developing countries access to information through the Internet remains unsatisfactory, so the aim is to provide this booklet in cheap hard-copy and in a form that can be sent by email.

A full copy of this report can be found at the PICU-Nurse-International website:
<http://groups.yahoo.com/group/PICU-Nurse-International> (just click on 'Files' after you have signed in on Yahoo – top of page – and then go to 'My Groups' and select PICU-Nurse-International).

A previous edition of the booklet is available at:
http://www.rch.org.au/emplibrary/cich/RCTs_devCountries_child_2004.pdf.

Critical Care Nursing Position Statements

This column highlights position statements that are pertinent to pediatric critical care nursing. Readers are encouraged to send any such documents that they would like to share with others to the Editor: Franco Carnevale Email: frank.carnevale@muhc.mcgill.ca

The World Federation of Critical Care Nurses

WFCCN has adopted the two following major Position Statements:

- Declaration of Buenos Aires: Position Statement on the Provision of Critical Care Nursing Workforce (27 August 2005)
- Declaration of Madrid: Position Statement on the Provision of Critical Care Nursing Education (27 August 2005)

These WFCCN Statements can be found in their entirety at the PICU-Nurse-International website: <http://groups.yahoo.com/group/PICU-Nurse-International> (just click on 'Files' after you have signed in on Yahoo – top of page – and then go to 'My Groups' and select PICU-Nurse-International).

Family Presence During Resuscitation

Canadian Association of Critical Care Nurses (CACCN)

Some of the key points from this statement include:

- CACCN supports providing families with the option of being present during resuscitation.
- CACCN respects the knowledge, skills and resources of families and believes in their capabilities.
- CACCN supports further research related to family presence and how it impacts the patient, family and health care professionals.
- CACCN encourages critical care nurses to develop educational resources for staff concerning the policy of family presence.
- CACCN encourages the development of an interdisciplinary approach toward family presence.
- CACCN supports critical care nurses in the development of policies and procedures supporting the option of family presence during resuscitation.

The entire policy, along with other CACCN policies can be found at: <http://www.caccn.ca/position.htm>

CONNECT
Official Journal of the World Federation of Critical Care Nurses

The main purpose of CONNECT is to provide a forum for critical care nurses around the world to share good practice. It aims to be the voice of critical care nurses world-wide. One of its founding principles is that of support of the Critical Care Nursing speciality. CONNECT aims to create a nurturing environment that enables all critical care nurses to have a voice. As such, the editors believe that all nurses have something valuable to contribute to CONNECT, that others may learn from. For this reason, no articles are rejected on the basis of language, and the editors undertake to provide help to authors, especially those writing in a second language. The main focus of CONNECT is clinical practice, and we (the editors) are particularly keen to receive articles that describe or evaluate developments in nursing. The journal contains a mixture of articles, including descriptions of practice innovation, literature reviews, letters, conference reports, clinical skills guidelines, news items, research and, of course, all the latest information about developments in WFCCN. Its aim is to be a friendly journal - one that nurses read because they are interested - and we make no apologies for its informal style!

CONNECT is produced in association with the European federation of Critical Care Nursing associations :
<http://www.wfccn.org/> <http://www.efccna.org/>

See Current Issue

<http://www.connectpublishing.com/current.asp>

2005 - Volume 4 Issue 2

This is my unit : the Critical Care Unit of Austral University Hospital, Buenos Aires, Argentina
Laura Alberto et al.

Critical care in Argentina
Laura Alberto et al.

The participant's view : critical care nurses' experiences of the 2nd Congress of the World
Federation of Critical Care Nurses in Argentina
Birte Baktoft & John Albarran

WFCCN Council Meeting, August 2005, Buenos Aires, Argentina
John Albarran

Nursing Abstracts from the 2nd Congress of the World Federation of Critical Care Nurses

Declaration of Buenos Aires: Position statement on the provision of critical care nursing workforce

Declaration of Madrid: Position statement on the provision of critical care nursing education

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Volume 6, Number 1, June 2005

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' after you have signed in on Yahoo – top of page – and then go to 'My Groups' and select PICU-Nurse-International).

Editorial

What can nurses do in the face of regional disasters?

Franco A. Carnevale, Canada

Insight into KKH Tsunami Relief Efforts

Pang Nguk Lan, Singapore

Lessons Learned from a Belgian Response to the Tsunami Disaster

Dirk Danschutter, Belgium

A Photographic Essay from the Tsunami Disaster

Dirk Danschutter, Belgium

Endotracheal Suction in Children and Neonates: Towards an Evidence-Based Technique

Beverley Copnell

Spotlight on PICU: Some Realities and Perspectives of Pediatric Critical Care Nursing in Brazil

Mavilde LG Pedreira. Maria Angélica S Peterlini.
Myriam AM Pettengill, Brazil

Pediatric Intensive Care Links

Come visit many interesting website links to various international nursing societies as well other important resources:

Go to our website: <http://groups.yahoo.com/group/PICU-Nurse-International> and click on 'Links'

Upcoming Conferences

3rd Congress of the World Federation of Critical Care Nurses & International Meeting of the Asia Pacific Federation of Critical Care Nurses

February 26-28, 2006
Century Park Hotel, Manila, Philippines
Hosted by Critical Care Nurses Association of the Philippines, Inc.

Congress Secretariat

8F Medical Arts Building, Philippine Heart Center
East Avenue, Quezon City, The Philippines
Tel.: +63 2 4264394 Fax: +63 2 4264394
Email: 3rdcongress@ccnapi.org Web site: <http://www.ccnapi.org/>

CRITICAL CARING: SPEAKING OUT FOR SICK Critical KIDS Coast to coast: Partnership in caring for sick children June 5 & 6, 2006 - Toronto, Ontario

CONFERENCE THEME

The theme of the Conference, "Coast to Coast: Partnership in Caring for Sick Children", is to enhance interdisciplinary care of neonatal and paediatric patients in critical care, NICU, and emergency room settings through sharing knowledge and expertise.

The goal is to explore both clinical and scientific topics relevant to health care professionals caring for critically ill neonates and children. The Conference Committee recognizes the interdisciplinary approach as the foundation to excellence in critical and emergency care. The Conference will include plenary sessions, presentation of research papers, as well as breakout workshops and special interest sessions.

CALL FOR ABSTRACTS

The Hospital for Sick Children is hosting a symposium for Neonatal/Paediatric Health Care Professionals. Abstracts are currently being accepted for oral and poster presentations. Emergency, neonatal, and paediatric critical care are the foci. We welcome presentations from all disciplines that practice in these areas. Topics that enhance the care of critically ill children and their families (clinical research, projects, case presentations, and clinical reviews) will be considered. Abstract submissions should demonstrate innovative critical care topics with the emphasis of team approach.

Please send submissions to:

Coast to coast: Partnership in Caring for Sick Children Abstracts
Attention: Lucy Costanzo
Paediatric Critical Care Unit, The Hospital for Sick Children
555 University Avenue, Toronto, Ontario, Canada M5G 1X8
Or e-mail: lucy.costanzo@sickkids.ca
Telephone: (416)813-4945 Fax: (416) 813-7299
Conference email: ccnursing.conference2006@sickkids.ca

**5th World Congress on Pediatric Critical Care
24-28 June 2007
Geneva, Switzerland**

Dear Colleagues,

On behalf of the Congress Organising Committee we are pleased to announce the 5th World Congress on Pediatric Critical Care, 24-28 June 2007, Geneva, Switzerland.

The vision of the Congress is "Dialogue around the World". We will bring together a high expert community that will share and exchange experience and knowledge in Pediatric Critical Care in a global perspective.

Please book these dates in your agenda as this major event in Pediatric Critical Care will be exciting and promises to be a great experience for all pediatric and neonatal critical care nurses around the World.

The 2nd announcement with the call for abstracts will be released early 2006. Of course we invite all of you to submit abstracts to have a comprehensive dialog with international colleagues.

Beside the scientific programme we will organise also pre-congress nursing post-graduate courses and symposia. If you are interested to organise a special nursing scientific event during the Congress days, please contact us.

The city of Geneva is very please to welcome all Pediatric Critical Care healthcare workers. Therefore, in collaboration with various companies and organisations we organise the "Sick Children Awareness Week" during the Congress days in Geneva.

Enough ingredients to come and celebrate our profession; Pediatric Critical Care!

Looking forward to welcoming you in Geneva 2007.

Warm regards,

Irene Harth and Jos Latour
Members of the Congress Organizing Committee
Email: jos.latour@planet.nl

Secretariat

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