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Craving togetherness: planning and replanning a national society hybrid conference during the COVID-19 pandemic

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Keywords: annual meeting; conference; COVID-19; medical society; virtual conference

Editor—On a positive note, the year 2020 will be known as the year of conference creativity. As the far-reaching consequences of the coronavirus disease 2019 (COVID-19) global pandemic became clear, conference organisers cancelled, postponed, or reconstructed long-planned conferences. Early in 2019, the Israel Society of Anesthesiologists (ISA) began planning the 2020 International Congress of the Israel Society of Anesthesiologists (ICISA). Every 3 yr, ICISA hosts a large prestigious international faculty in a Tel Aviv beachfront conference hotel. In intervening years, the ISA holds its annual conference comprising mostly Israeli faculty. With the emergence of COVID-19 in Israel in March 2020, the ISA began tracking the rising number of cases. By May 2020, ISA board members voted to postpone ICISA, and instead hold

an in-person annual conference. Here, we will describe the challenges associated with transforming our conference in a rapidly changing environment. The ISA conference was named 'Anaesthesia—the Forefront of Medicine' to reflect our work during the COVID-19 pandemic. New COVID-19 panels were created in addition to other scientific updates.

By June 2020, it was clear that an in-person conference was likely impossible. However, we wished to maintain a sense of community, which is difficult in virtual conferences, such as those presented by the ASA and the European Society of Anaesthesiology and Intensive Care amongst others.^{1–3} Although virtual conferences are the current norm, attendees yearn for in-person conferences.⁴ We surmised that a communal conference experience would entice and engage attendees, and help with professional isolation and burnout,

as physicians are already overwhelmed with virtual conferences and webinars.⁵ Thus, we conceived a hybrid programme. We started with the scientific programme on Day 1 and continued with workshops/simulations and abstract presentations on Day 2, adhering to COVID-19 regulations (social distancing and limited attendance gathered in an enclosed space). Our guiding principles included engendering a feeling of togetherness, retaining a broad novel scientific programme, in-person workshops/simulations, and high exposure to industry.

Each medical centre became a viewing hub, enabling unified viewing. Anaesthetists working in that centre could gather in the hub, or view from work or home if preferred. Since July 2020, maximum room occupancy was limited; thus, some centres required several communal viewing hubs.

We created a programme with four scientific broadcast channels, one live and three pre-recorded, plus a fifth industry channel. The live channel was broadcast from two hubs, in Tel Aviv and in Jerusalem, and presenters attended these in person. The viewing platform had a community chat system, where attendees could interact with others around the country. We provided earphones for personal devices that enabled attendees to view their chosen channel, and the live channel was broadcast on the hub auditorium screen. We provided a luxury finger food dinner box (to avoid food handling) sent to each hub for a post-conference COVID-19 appropriate social experience.

To maintain consciousness of communal attendance, a live-broadcast plenary session was held after each multiple viewing channel session; thus, attendees were regularly

returned to the live experience milieu. **Figure 1** shows plenary panellists, holding individual microphones and wearing surgical face masks.

To retain the broad scientific content intended for a 2 day programme, in the shortened 4 h programme, lectures were allocated 10 min time limits and speakers were asked to present the topic highlights. Live speaker timings were controlled by a moderator, and speakers unable to attend a live broadcast hub in person were sent pre-recorded lectures slotted into the live sessions. This facilitated synchronised concurrent broadcast from the live and pre-recorded channels. During the pre-recorded lectures, speakers received questions via the chat function, and for live lectures, speakers received questions following their lecture.

On September 18, 2020, Israel entered a second lockdown, closing hotels and conference centres. Not willing to give up on in-person workshops/simulations and abstract presentations, these were relocated to the Tel Aviv Medical Center. On October 14, 2020 (9 days before the workshops), we intended to reassess the situation, given the enforced 1000 m travel restriction that continued until October 18, 2020. As workshops were held inside the Tel Aviv Medical Center, this facilitated delaying the 'go' decision until October 18, 2020.

The seven workshops/simulations parallel tracks were constructed in 60 min blocks, with a 10 min transfer time to minimise mingling. Each workshop was limited to five to eight attendees to allow two instructors and remain at or below the maximum of 10 people allowed per room. Airway workshops were held in operating theatres, largely available on Friday. We split the simulation programme between the Medical



Fig 1. Moderated plenary panel with coronavirus disease 2019 restrictions, including panellists wearing surgical face masks and holding individual microphones.

Technology and Simulation Center (MTS) and the operating theatre, providing an *in situ* operating theatre simulation track using an advanced medical simulator.⁶ Equipment workshops were held in the MTS. Problem-based learning was held in conference rooms and ultrasound (regional and point-of-care tracks) in the admission area and in conference rooms. Abstracts were presented using the hybrid format through in-person attendance or virtually.

The ISA conferences are strongly supported by the industry. As it became clear that in-person interaction with the industry was impossible, our supporters nimbly switched to an online platform. We offered promotional opportunities, including a digital magazine published before the conference. This allowed the industry to present videos and podcasts of their advances and technology. In addition, during the streaming of the hybrid conference, a viewing channel offered industry-sponsored content, with links to video on demand and chat with company representatives. We achieved industry support that was only 17% lower than the level achieved in the 2019 in-person conference.

Amongst the 800 Israeli anaesthetists, more than 500 attended, plus 78 industry delegates. Considering the hybrid format, this compares well with in-person attendee numbers for 2018 and 2019: 559 (2018) and 638 (2019) for the scientific programme, and 196 (2018) and 275 (2019) for the workshops.

In conclusion, our colleagues supported the communal learning platform, reflected by registration that exceeded our expectations. The hybrid format satisfied our guiding principles, enabling a community experience, with a broad high-quality scientific programme, well-attended workshops, and substantial support from our industry partners who were extremely satisfied with their visibility and interaction with

the attendees. As many attendees shared, 'we really missed this'.

Declarations of interest

The authors declare that they have no conflicts of interest.

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Effects of the COVID-19 pandemic on environmental sustainability in anaesthesia. Comment on Br J Anaesth 2020; 125: 680-92

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Keywords: COVID-19; environmental impact; general anaesthesia; life-cycle assessment; regional anaesthesia; resource management

Editor—The timely and comprehensive review of the environmental impacts of anaesthesia by McGain and colleagues¹ highlights the urgency of the changes that need to be made, both by individual practitioners and by the profession worldwide. The authors are correct in stressing the need for further research into life-cycle assessment and for innovation in waste and resource management. But, might the coronavirus disease 2019 (COVID-19) pandemic affect

this important transition towards a carbon-neutral profession?

For example, understandable concerns about nosocomial COVID-19 transmission have resulted in significant per-case increases in plastic use and incineration and decreases in non-plastic recycling. These are in line with non-medical national and international trends,² and are often sanctioned by governments, but could be reversible