Organ donation in Australia and New Zealand

Stephen Streat and Stewart Moodie

Organ donation remains a continued source of public debate in both Australia and New Zealand, with frequent media reporting of statements by politicians, lobbyists and transplant professionals while the voices of intensivists have been comparatively silent. The commonly recurring reported themes include “low donor rates”, comparisons of “donor rates” with those of Spain (and “Croatia, Portugal and the USA”), stories of recipients waiting anxiously for transplants, reports of “death on the waiting list”, suggestions that “someone is to blame” and strident statements that various administrative and legislative changes are “necessary or required” and will then “fix the organ shortage problem”. In response to political pressure, the Governments of both countries have recently announced that they will conduct reviews of donation (and some aspects of transplantation). The terms of reference of the Australian review, to be conducted by Ernst and Young, have been released while in New Zealand these have yet to be finalised and are not yet available.

In 2008 the Australian Government invested an additional approximately $A40m p.a. to establish the Organ and Tissue Authority (OTA) that supports organ donation and transplantation activities in Australia. Similar funding remains ongoing. In 2013 the New Zealand Government allocated an additional $NZ1m p.a. (for four years) to donation, half of which went to transplant services to support live-donor kidney donation and half to ODNZ to support deceased donation.

Subsequent to the additional funding, organ donation rates2 have risen in Australia, from an average of 10.3 donors per million per year (dpmpy) in 2005-2008 to 16.1 in 2014, in large part due to substantial increases in DCD donation which now makes up around 27% of deceased donation. In absolute terms DCD rates in Australia2 in 2014 (4.6 dpmpy) are similar to those of the USA (4.5) and Spain (4.1) although there are large variations between Australian hospitals and jurisdictions. In New Zealand, where DCD is less well established, there has been a smaller increase in donation rate3 (from an average of 7.3 dpmpy in 2005-2008 to 10.2 in 2014), and DCD only made up around 10% of deceased donation in 2014.

[Both countries2 have relatively high rates of live (mostly kidney) donation in international comparisons (Australia 11.5, New Zealand 16.9 dpmpy) and, together with deceased donors, this enabled 38.5 Australians and 30.7 New Zealanders per million to receive an organ transplant in 2014].

The two underlying determining factors in deceased organ donation are the rate of family agreement to donation and the number of clinical situations where donation is possible (the incidence of brain death and of predicted circulatory death within a specified timeframe). The clinical situations where donation is possible are driven both by factors external to the hospital (e.g. the incidence and severity of traumatic brain injury, intracranial bleeding and post-arrest hypoxic ischaemic encephalopathy in particular) as well as by clinical practices within the hospital and within the ICU. These include the extent to which the ICU is seen as a necessary or usual “locus of treatment or death” for patients with extremely severe (possibly fatal) brain damage, the availability of ICU resources, the use of various clinical treatments (e.g. surgical measures to control intracranial hypertension) and the timing and willingness of clinicians and families to initiate and to withdraw ventilation and other intensive treatments. It is likely that the higher rates of donation seen in other countries are directly related to differences in these practices (e.g. so-called ‘elective ventilation’ in a manner described in Spain4), which are unlikely to be currently acceptable in Australian or New Zealand society5.

In both countries, a succession of injury prevention initiatives over a long time (particularly in Australia) have lowered the incidence of life-threatening injury (including TBI) and this is reflected in substantial change in the characteristics of actual deceased donors. Historically, (and often still in the minds of the public and the media) donors were most commonly young people with TBI but now they are older and most commonly have died as a result of either spontaneous intracranial bleeding or hypoxic-ischaemic encephalopathy. Changes in the demography of fatal brain damage emphasise the importance of clinical staff identifying and recognising every situation where donation might be possible, and supporting that opportunity appropriately so that donation can take place under appropriate clinical and family circumstances.

Identification of the possibility that donation might occur is a key step in the organ donation process, which is assisted in various ways by “triggers” and other screening processes, including by specialist medical and nursing staff with expertise in organ (and tissue) donation. In Australia this issue has been addressed in a number of ways by OTA through engagement of clinical intensive care and emergency department staff. In New Zealand ODNZ has produced a free smartphone application for health professionals involved in organ donation. This assists ICU medical and nursing staff to identify situations of potential donation and consult ODNZ for advice and support (which includes routine consultation with a senior intensivist), as well as in other aspects of the donation process (e.g. determination of brain death, physiological support and problem-solving, legal and consent issues and the discussion of donation with the family). It seems likely to us that there is some further scope for improvement in the identification of potential donation situations, and in processes of consultation with “organ donation staff” whose special expertise in donation might then be helpfully used by the staff caring for the patient and their family.

Clinical audit processes have been set up in both countries to determine the potential for donation and recognise where practice changes may allow for more donation without compromising good medical practice, ethical or legal standards. New Zealand has a comprehensive on-line national audit of all ICU deaths which collects similar data elements to the UK audit6. (There is currently no similar audit of patients who might, under some circumstances, donate but are not admitted to an ICU.) Data on every death in every New Zealand ICU are entered soon after the death by specialist organ donation nurses. These data have revealed areas of unexplained clinical practice variation in key aspects of the donation process and have led, through ICU-specific feedback and clinical review processes, to changes in some of these processes. Within Australia, OTA has similarly developed a detailed national death audit process to identify where opportunities to offer organ donation to families have been unrealised. It is the nature of audit processes that they continue to be refined and enhanced over time, as they reveal areas of needed attention. It seems to us likely that recent increases in donation have resulted from attention to the drivers of donation within ICU practice, supported by the information obtained in such audit processes.

ANZICS has always recognised and supported the central role of intensivists in organ donation and provides guidance to intensivists and others in its Statement on Death and Organ Donation7. ANZICS recognises and continues to advocate for the professional responsibilities of intensivists in supporting organ donation and states specifically that: “Intensivists have responsibilities in all of the following components of the donation process:

- care of the dying patient;
- care of the family;
- recognising the possibility of organ and tissue donation;
• determination of death (through loss of brain function or cessation of circulation);
• respectful treatment of the deceased patient;
• discussing the option of donation with the family;
• liaison with the donor coordination service (which in turn liaises with organ and tissue removal and transplantation services);
• maintaining physiological stability and good organ function until organ removal; and
• providing aftercare for the family of the deceased patient, irrespective of whether or not donation takes place.”

Considerable attention has been paid by ANZICS, OTA, ODNZ and the College of Intensive Care Medicine (CICM) to developing organ donation good practice and enhancing cooperation and collaboration in donation between intensivists and other clinical staff, donation agencies and transplantation services. One specific shared goal has been to improve the quality of communication around donation. ANZICS supports that all Australian intensivists should attend the core Family Donation Conversation Workshops that have been provided by OTA with significant input by our professional bodies. ODNZ is hosting the first of these in New Zealand, (delivered by OTA), in November this year and will seek feedback from the participants (largely senior specialist nurses and doctors involved in organ donation). Improving the quality of communication is a key aspect of intensive care, will hopefully improve care to families and may also increase donation rates. Further collaboration will involve increased mutual understanding, ongoing education and training programs, specific funding for some hospital-based staff, harmonisation of terminology and acceptance of the idea that “donation is everyone’s responsibility”. Ensuring that opportunities for possible donation are not missed and how best to discuss the possibility of donation with the family requires that such close cooperation must continue.

Attention to the integrity, consistency and robustness of all of the “system” processes involved in donation (which do alter the rate of organ donation) should not be allowed to weaken or be deflected by calls for “reforms” espousing changes in administrative or legal processes (such as registers, consent frameworks and law changes) for which evidence of efficacy is lacking and evidence of ethical acceptability is at least controversial or unproven[3].

It seems likely to us that moderate increases in donation (especially in DCD) might be possible in NZ, and to a lesser extent in Australia. However it seems unlikely that large increases will occur to the levels found in some countries with very different health care systems, demography of brain death, ICU utilization and end-of-life care practices.

Intensivists must remain committed to donation, including being committed to good medical practice, ethical standards and the law. Only then can we retain our moral authority to advocate for integrity in all aspects of the donation process, especially now, when increasing political pressure is being brought to bear to “get more donors” and where welcome ongoing Government investment in donation-related initiatives are potentially in jeopardy.

References
2) International Registry in Organ Donation and Transplantation (iRODaT), available at http://www.irodat.org/

Declaration of interests
Stephen Streat is an intensivist at the Department of Critical Care Medicine, Auckland City Hospital and Clinical Director of Organ Donation New Zealand, the national agency for deceased organ donation. Stewart Moodie is an intensivist at the Queen Elizabeth and Royal Adelaide Hospitals in Adelaide and State Medical Director for OTA for South Australia. Both are members of the ANZICS Death and Organ Donation Committee and the ANZICS End of Life Care Working Group.
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Registrations Open ........................................ 23 February 2015
Abstract Submission Deadline ....................... 6 July 2015
Early Bird Registration Deadline ................. 17 August 2015

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President’s Report

The Society is a small business with significant outputs including research, quality assurance, education, patient care, and advocacy both industrial and for the craft group as a whole. Our subscriptions make a small contribution only to the total revenue of the Society, with much of the “good works” being funded externally. This financial year the Society has traded at a small loss, which is a good result given that there was originally a significantly higher budgeted deficit forecast. Unfortunately our current income streams do not permit the Society to realistically develop new projects unless there is a likelihood of revenue generation. All of the work that is done by the Society is performed in order to improve ICU as a craft group within our two countries, and a strong and effective Society is needed in order to prevent a slow decline in ICU outcomes and intensivist conditions.

Society attendance at meetings in the Middle East and in Singapore have demonstrated that the Society is held in high regard outside our two countries and there is a genuine desire for our systems to be utilised elsewhere in order to improve patient care and advance the local craft group. In particular the CORE database is seen to be an important quality assurance tool that is recognised to give high quality reports and allowing benchmarking against peers. Likewise the systems developed by the CTG are also sought after by countries that have a desire to commence collaborative multi-centre trials.

At the recent Board meeting the importance of developing international linkages was recognised and it was agreed that a Board Member be tasked with an international liaison portfolio. Stephen Warrillow was unanimously elected to this position.

The Singapore Society encouraged nurses to attend the SG-ANZICS Intensive Care Forum, because it was recognised that the collaborative approach that underpins the ANZICS ASM is an important driver of improved outcomes in ICU in ANZ, and to date there is little high level education for ICU nurses in Singapore. A significant number of nurses from the SEA region attended the meeting and their attendance significantly increased the size and the success of the meeting. The Society already administers the IRCIG group of nurses and has a number of affiliate members. I believe that we can advocate from a position of greater strength by representing medical, nursing and allied health intensive care colleagues, and any increase in our membership base would be good both for the Society and for all professionals involved in ICU.

As a State Medical Director for DonateLife I continue to ensure that organ donation issues are dealt with through other members of the Society Executive. Likewise the DODC committee consists of experts in organ donation, however limits DonateLife employees to less than 50 percent of the committee membership. Following the recently announced Federal review of organ donation conducted by Ernst and Young, I requested the Executive and DODC to determine if a response should be forthcoming from the Society. It was agreed that recent gains in organ donation rates would be put at risk if a major change to the current organ donation systems was recommended by the review, and as a result the Society responded to the Minister, and has participated in the FY review.

Rapid Response Teams (RRT) are now a significant part of intensive care work across our two countries. The importance of this workload has prompted a joint working group to be formed between ANZICS and the College. It is anticipated that a number of consensus statements will be created next year as a result of the work that is being conducted. Following the success of last year’s SQAO conference themed on RRT, the recently run SQAO meeting was again themed on the deteriorating patient, and the meeting included content to assist in the development of training materials for team members. The meeting was convened by Daryl Jones, was held on the Gold Coast and was highly successful with a significant attendance number. The faculty included current President of the International Society of Rapid response Systems –Michael DeVita, and RRT training tools should be developed in the near future, based on interactive feedback during the meeting. Next year the twelfth International Conference on Rapid Response Teams will be held in Melbourne, on the 2nd and 3rd of May, and this meeting and the current work being undertaken by the Society should confirm ANZICS position as the world expert in RRTs.

The Clinical Trials Group 17th Annual Meeting on Clinical Trials in Intensive Care was held on Tuesday 3rd to Friday 6th March 2015 in Noosa. This meeting was highly successful, and reportedly was one of the best meetings in recent times. The Winter Research Forum was recently held on the Gold Coast in conjunction with the Safety and Quality Meeting and CORE. This week on the Gold Coast was a terrific promotion for ANZICS, and I thank the organisers and all who attended. Other meetings to be held this year include the ASM on 29th to 31st October in Auckland, the theme is Intensive Care Under Pressure, and the program is of an exceptional quality. Once again the ASM will include the Global Rising Star Programme. The inaugural Victorian Primary Examination Course for CJM will be held at ANZICS House on the 10th of October. The ICM course will be held in early November 2015, in collaboration with Eastern Health. The focus for this course will change to a simulation based course targeting areas of ICU care that ICU registrars commonly face.

The importance of education to the Society and our members has been recognised by the Board, and at the recent Board Meeting it was agreed that there must always be at least one Education Committee member who is a Director of the Society. This Director will interface with the Committee and Board to ensure that strategic priorities are recognised and acted upon.

ANZICS and the College have committed to a joint response to Choosing Wisely Australia. As our submission develops we will inform members and Fellows of the suggested proposals in order to allow feedback.

Finally, I must give thanks to Colin McArthur who stepped down as Chair of the CTG in June having been in this role for two years. Colin has been tireless in his work for the CTG and Society, and must be congratulated for the achievements of the CTG over the last two years. Colin will remain an Office Bearer as Immediate Past Chair allowing a smooth transition for Craig French, who is the new Chair. Also, of significance I would like to acknowledge that Rachael Parke, who has been Chair of the Intensive Care Research Coordinators Interest Group, has been elected to the CTG Executive as Secretary.

Andrew Turner
ANZICS President

ANZICS Board Members
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CTG Chair Craig French
Paediatric Chair Johnny Millar
Since the last edition of The Intensivist we have gained 19 new Members. Unfortunately 6 Members have resigned due to outstanding fees, requests to discontinue, moving overseas and retirement. I would like to express my gratitude to all of our Members, Regional Chairs, LinkPersons and our Committee Members who have helped to promote and spread the word of ANZICS and the work it does for Australian and New Zealand Intensive Care Medicine. While we have had steady growth in new Members to the Society, I would like to remind those Members with outstanding subscriptions to please make payment on these as soon as possible. Discounted rates have now been introduced for new Full Members and for Trainee Members who are progressing to Full Members. Please see the ANZICS website for full details and prices.

Although we have always been successful in recruiting new Members, I must encourage all ANZICS members to continue to promote the Society and encourage people working within our specialty to join ANZICS. It is also important to encourage all members to get involved in the Society’s Committees and activities, as we need a variety of people in these roles to keep ANZICS growing. The Society is a reflection of its membership and the important work completed by ANZICS is dependent on them.

ANZICS is pleased to announce Trainees are now eligible to express interest in Committee positions.

The Society is devoted to its members and would like to continue to encourage young professionals in our specialty to remain a part of ANZICS.

Simon Erickson
Honorary Secretary

Membership Report

Please welcome the following new members:

Angelly Martinez
Gold Coast University Hospital, QLD

Clayton Sibbin
Flinders Medical Centre, SA

Fiona Mitchell
NETS, NSW

Damian Bradley
Fiona Stanley Hospital, WA

Nicky Dobos
Royal Melbourne Hospital, VIC

Montaha Wajid Khan
Liverpool Hospital, NSW

Isuru Seneviratne
The Prince Charles Hospital, QLD

Li Tan
Epworth Hospital, VIC

Namita Warrior
Western Health, VIC

Sankalp Purwar
Flinders Medical Centre, SA

Arne Diehl
The Northern Hospital, VIC

Victor Liew
Queen Elizabeth Hospital, SA

Sione Tukia
Starship Hospital, ADHB, NZ

Ryan Jang
Rotorua Hospital, NZ

Paul Spedding
Joondalup Health Campus, WA

Mohammad Alkhateeb
King Khalid University Hospital at King Saud Medi, Jordan

Nitin Chavan
Coffs Harbour Base Hospital, NSW

Alison Walker
Mildura Base Hospital, VIC

Luregn Schlapbach
Lady Cilento Children’s Hospital, QLD
With this episode of the Intensivist, we focus on “involvement in ANZICS CORE”. There are ways to be involved beyond just submission of data and looking at the reports.

The ANZICS CORE Outlier Working Group

Every quarter, annual standardised mortality ratios (SMR) for ICUs in Australia and New Zealand are produced and made available through the ANZICS CORE Reporting Portal [https://coreportal.anzics.com.au]. Inevitably, from time to time, an ICU will appear with an SMR higher than their comparison peer group. The ICU is notified that CORE will then undertake a tiered process of analysis which examines data quality (about a third of “outliers” appear to be partly or wholly explained by this), the effect of case mix and finally reported resources and staffing. A single report is then produced and sent simultaneously to the ICU Director, CEO and local governance bodies/health departments. This is one of the primary purposes of ANZICS CORE and what we are funded to do by the regional health departments.

The aim is always to provide a report which is useful and one that accurately reflects data collected and sent to CORE. Outside of data quality audits, CORE does not do on-site inspections, does not and cannot comment on practices within the ICU, and all reports remain completely confidential until released to the ICU. The report goes as far as it can to explain the SMR, but does not offer advice or recommendations about action. Each report takes a huge amount of work and is produced jointly by staff at CORE and by independent clinicians. Until recently this clinical input has been provided by a small group of Intensivists who provide time and confidential advice to staff at ANZICS CORE. As the workload and complexity of the reports continues to increase and in recognition of the need to ensure regional representation, the ANZICS CORE Outlier Working Group has recently been created. We welcome the following individuals:

**Working Party Member** | **Representation**
--- | ---
Tony Williams & Cameron Knott | New Zealand
Deepak Bhonagiri | Victoria
Dan Mullany & Geoff Dobb | New South Wales & ACT
Santosh Verghese & Matthew Anstey | South Australia & Northern Territory
Johnny Millar | Paediatrics
Shay McGuinness & Andrew Udy | Co-opted
Frank van Haren | New South Wales & ACT
Jeff Presneill | Queensland
Michael Bailey | Co-opted
Rinaldo Bellomo | Victoria
Matthew Anstey | Western Australia

With their help, we look forward to on-going collaboration and furthering the research output from ANZICS CORE.

The ANZICS CORE Research and Publication Working Group

Over the past 5-10 years, the research output from ANZICS CORE has progressively increased. Notable recent publications from both the Adult and Paediatric groups in NEJM, JAMA and the Lancet have showcased the excellent outcomes of patients with sepsis in our ICUs – even the Americans at SMACC in Chicago made a point of bagging us for telling the world how good we were! However to produce research output is not easy, requires careful governance of data, high levels of input from interested clinicians and statisticians which is often completely unfunded. In an effort to further promote CORE’s research output, provide mechanisms to support research and guide new researchers, we welcome the following individuals onto the ANZICS CORE Research and Publication working group:

**Working Party Member** | **Representation**
--- | ---
Shay McGuinness & Andrew Udy | Co-opted
Frank van Haren | New South Wales & ACT
Jeff Presneill | Queensland
Michael Bailey | Co-opted
Rinaldo Bellomo | Victoria
Matthew Anstey | Western Australia

With their help, we look forward to on-going collaboration and furthering the research output from ANZICS CORE.

Are you in CORE?

Last year there were over 130,000 adult and 20,000 paediatric ICU admissions reported to ANZICS CORE. All tertiary hospital ICUs throughout Australia and New Zealand contribute data (with only one persistent exception!!). All metropolitan ICUs in Victoria, Queensland, South Australia and Western Australia contribute. ICUs in Hong Kong and India already use CORE’s services and hospitals in other parts of the world are also considering joining. If you are one of the few missing out, please contact us at anzics.core@anzics.com.au.

Yours,

Dave Pilcher and the ANZICS CORE Management Committee
In June elections were held for the officer bearer positions of the Clinical Trials Group. The results are:

**Chair:** Craig French  
**Vice-Chair:** Sandra Peake  
**Treasurer:** David Gattas  
**Secretary:** Rachael Parke

I thank Colin McArthur for his fantastic contribution to the CTG as Chair over the last two years. Colin continues on the Executive as the immediate past Chair. I also thank, and acknowledge the contribution of, Steve Webb who “retires” from the CTG committee after a decade of service. Rachael Parke joins the CTG committee as an officer bearer; this creates a vacancy on the committee for an IRCIG representative. Committees are more likely to be effective if they are diverse: the increase in the number of research coordinators on the CTG committee facilitates such diversity.

Elections for regional and IRCIG representatives will be held later this year.

The CTG is currently preparing for our Winter Research Forum: this year it being held during school holidays for most jurisdictions in Australia and New Zealand. Consequently the venue chosen was the SeaWorld Conference Centre on the Gold Coast. It is hoped that while ICU clinicians are engaged in the meeting their families may enjoy the many attractions this region offers.

Our winter meeting provides a forum for research projects that are in their early stages of development to be presented and discussed in addition to those that are ready for the definitive multicentre RCT. This year is no exception with the program including proposals ranging from observational studies of patients with subarachnoid haemorrhage, phase II RCTs and updates from recently funded multicentre RCTs.

A major challenge facing the conduct of research in the critical and emergency environments is consent. While the NHMRC provide guidance regarding this in their National Statement differences in law between jurisdictions exist. The consequence of this is that a method of consent considered ethical under the National Statement may be legal in one jurisdiction and illegal in another. Interpretation of the law may also change. This was recently highlighted in NSW where two rulings of the Guardianship Division of the NSW Civil and Administrative Tribunal raised doubt about the legality of the consent process for two CTG endorsed multicentre trials- ADRENAL (hydrocortisone versus placebo for septic shock) and TRANSFUSE (freshest available versus standard issue red blood cells). The management committees of both trials elected to suspend recruitment until this matter was clarified.

I pleased to report that in June, after a troubling few months, the Guardianship Division of the NSW Civil and Administrative Tribunal has ruled that the consent processes utilised by (with Human Research Ethics Committee Approval) these studies is appropriate under NSW law. This is an exceptional outcome. I would like to acknowledge the contributions of John Myburgh, Jamie Cooper, Bala Venkatash and the legal teams supporting the George Institute for Global Health and the Australian and New Zealand Intensive Care Research Centre. The coordinated and collegial approach helped ensure success. While these trials are back up and running legal ambiguity regarding consent still exists in NSW. The CTG will continue to work with methods centres, the Australian Clinical Trials Alliance, and the NSW Office for Medical Health and Research to obtain the necessary legislative and/or regulatory change required for clarity.

Craig French  
Chair, Clinical Trials Group

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**CTG Committee Members**

**Chair:** Craig French  
**Immediate Past Chair:** Colin McArthur  
**Vice Chair:** Sandra Peake  
**Treasurer:** David Gattas  
**Secretary:** Rachael Parke  
**NSW:** Manoj Saxena  
**NZ:** Shay McGuiness  
**QLD:** Michael Reade  
**SA:** Adam Deane  
**TAS:** David Cooper  
**VIC:** Neil Orford  
**WA:** Ed Litton  
**CORE:** David Pilcher  
**IRCIG:** Vacant  
**PSG:** Simon Erickson
Core Family Donation Conversation Workshops

In 2014 ANZICS DODC worked with CICM and the Australian Organ & Tissue Authority (OTA) to develop a new course to replace Medical ADAPT in Australia. The ANZICS DODC along with CICM revised the old workshop developed by OTA and provided feedback based on the learning materials and pilot workshop that was attended by a number of DODC members in March 2014. Whilst this feedback was acknowledged by OTA, the ANZICS DODC will provide additional feedback in response to OTAs revisions during the next consultation period. The DODC also continues to work with CICM to develop relevant on-line teaching materials for trainees and fellows. ANZICS and CICM retain extended representation on the OTA Family Conversation Steering Group. During this time a draft tripartite Memorandum of Understanding (MOU) between ANZICS, CICM and OTA was sent to OTA but is yet to be finalised.

Preliminary results of the Collaborative Requesting Model piloted by OTA

OTA engaged A/Prof Virginia Lewis from La Trobe University to evaluate a national pilot of the Collaborative Requesting Model (CRM) across 15 hospitals in Australia from March 2013 to May 2015. The aim of the pilot was to evaluate the impact of the Family Donation Conversation (FDC) workshops on the way health professionals manage conversations with families when discussing organ and tissue donation, and to examine the impact of the pilot CRM on donation requesting processes.

The CRM is designed to support families to make an informed decision about donation. The CRM involves earlier engagement of donation specialist staff and includes the presence of a donation specialist in the first conversation when donation is initially raised with the family. In the CRM the donation specialist provides information to the family on the donation process, adopts a ‘balanced approach’, answers questions and makes the request for donation. Data has been collected thus far from 201 FDCs, from one or more participants in 172 FDCs, from at least one ICU doctor in 112 FDCs and from 136 feedback surveys completed by ICU doctors. The preliminary results show:

- 84% of ICU doctors agreed that only staff with special training in how to have conversations about donation should ask families about organ and tissue donation;
- 96% agreed that they were comfortable participating in a FDC with someone else leading it;
- 92% of trained requestors agreed the FDC Core Workshop helped them with the FDC process, adopts a ‘balanced approach’, answers questions and makes the request for donation. The CRM is designed to support families to make an informed decision about donation. The CRM involves earlier engagement of donation specialist staff and includes the presence of a donation specialist in the first conversation when donation is initially raised with the family. In the CRM the donation specialist provides information to the family on the donation process, adopts a ‘balanced approach’, answers questions and makes the request for donation. Data has been collected thus far from 201 FDCs, from one or more participants in 172 FDCs, from at least one ICU doctor in 112 FDCs and from 136 feedback surveys completed by ICU doctors. The preliminary results show:

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- 96% agreed that they were comfortable participating in a FDC with someone else leading it;
- 92% of trained requestors agreed the FDC Core Workshop helped them with the FDC process, adopts a ‘balanced approach’, answers questions and makes the request for donation. Evaluation results of the pilot will be published in the near future and will be made available to the DonateLife Clinical Governance Committee to inform a national best practice model for conduct of the family donation conversation. The DODC also welcomes your comments on these preliminary findings. Please send them to Jessyca Menzel at jessyca.menzel@anzics.com.au.

OTA

Some of you may be aware of the recent government announcement to review OTAs organ donation and transplantation programme. ANZICS have released a statement in support of OTA and the organ donation and transplantation programme, this has been sent to the media, ANZICS members and is available on the ANZICS website.

End-of-Life Care Working Group

ANZICS Statement on Care and Decision Making at the End-of-Life for the Critically Ill was released and endorsed by the ANZICS Board late in 2014. The Statement is a culmination of a large body of work by the End-of-Life Care Working Group and broad consultation of the ANZICS membership and external bodies. Since its publication, there has been an opportunity to promote the statement on Radio National’s Health report with Dr. Norman Swan as well as via a podcast with Neil Orford. The Statement will periodically be reviewed by the EOLCWG to ensure it remains relevant and up to date and I encourage any comments or feedback to be submitted to Jessyca Menzel. On behalf of the EOLCWG, I wish to thank the ANZICS membership for their input and support.

ANZICS Statement on Death and Organ Donation

A reminder to all members that The ANZICS Statement on Death and Organ Donation edition 3.2 is also available on the ANZICS website.

I would like to express my gratitude to all members of the DODC and the EOLCWG and to the ANZICS staff for their immense contribution to the work of these two committees this year. I look forward to 2015-2016 being an equally productive year.

A/Prof. Bill Silvester
Chair, Death and Organ Donation Committee
Chair, End-of-Life Care Working Group

Committee Membership

A/Prof. William Silvester - (Chair) (VIC)
Professor Geoff Dobb - (WA)
A/Prof. Brent Richards - (QLD)
A/Prof. Mary White - (SA)
Dr Stephen Streat - (NZ)
Dr Johnny Millar - (Paediatric)
Dr Stewart Moodie - (SA)
Dr Deepak Bhonagiri - (NSW)
Dr James Judson - (NZ)
Dr Helen Opdam - (VIC)

EOLCWG Membership

A/Prof. William Silvester - (Chair) (VIC)
Dr Stewart Moodie – (Deputy Chair) (SA)
Professor Malcolm Fisher – (NSW)
Professor Ken Hillman (Advisory only) – (NSW)
A/Prof. Brent Richards – (QLD)
A/Prof. Theresa Jacques - (NSW)
Dr Stephen Streat - (NZ)
Dr James Judson - (NZ)
Dr Peter Saul - (NSW)
Dr Stephen Jacobs (Paediatric) – (NSW)
Dr Charlie Corke (CICM Representative) - (VIC)
Dr Penny Stewart (NT)
Dr Dominic Wilkinson (SA)
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>405</td>
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<tr>
<td>Trainee/SAS</td>
<td>365</td>
<td>475</td>
</tr>
<tr>
<td>Nurse/AHP</td>
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<td>210</td>
</tr>
</tbody>
</table>

Registration, abstract submission and day rates at www.soa.ics.ac.uk

15 CPD POINTS PENDING
Education Committee

The ANZICS Education Committee was established in part to investigate and implement ways for the Society to become more engaged with new consultants and senior trainees in Intensive Care Medicine. The ANZICS Education Committee has identified the opportunity for complimentary training for new intensivists, which shows them how to use the tools at their disposal from within the Society and the broader Intensive Care community, for the benefit of their unit and their professional development.

Since the last edition of the Intensivist, the Education Committee has met twice via teleconference and gained a new representative from WA, Anthony Tzannes. The position for NZ representative is currently vacant, an EOI for this role will be sent out to NZ members shortly.

The Foundation Workshop for the New Intensivist was a success at the 2014 ASM in Melbourne and plans are currently underway for the Auckland 2015 ASM. The workshop is designed to complement the content of transition to consultant courses which are now mandatory for Fellows of the College of Intensive Care Medicine, and is intended as an introduction for Senior Registrars and new Consultants on how best to utilise the tools that the Society offers. The committee is committed to continuing to engage new consultants and trainees in this course and other educational ANZICS programs. It is anticipated that the course will evolve into a full day program that is likely to be conducted on the day immediately prior to future ASMs.

The ANZICS ICM course that was impeccably convened by the late A/Professor Ramesh Nagappan for 7 years was postponed in 2014 due to his untimely passing. The Education Committee is currently in discussions with Eastern Health in Victoria regarding the development and convening of a course for 2015.

Another initiative of the Education Committee in 2015 will be to further develop an online Education system. To date, content has been taken from a variety of areas such as the 2013 and 2014 ASMs and Safety and Quality and has been made available online. Material will continue to be added from future ASMs as well as from other committees of the Society.

The formation of a subcommittee, the ANZICS Communications & Social Media Working Group is also in progress. This working group will assist the Education Committee in:

- Developing and maintaining an effective communications strategy for ANZICS to ensure the organisation remains current and implements effective use of social media.
- Ensuring the promotion of web based educational opportunities for members.
- Supporting engagement between ANZICS with trainees in intensive care through the provision of relevant online education, training programs and social media.
- Identifying gaps and deficiencies in currently available education and training that may be improved via the web-based training.

Throughout 2015 the Education Committee will continue to meet to further develop the 2015 ICM Course, future ASMs and the online Education system. Details will be distributed through member lists as they become available.

Please continue to provide feedback and suggestions to Jessyca Menzel via Jessyca.menzel@anzics.com.au.

Stephen Warrillow
Acting Chair, Education Committee
VPECC
The Victorian Primary Examination Course for CICM

Saturday 10th October 2015
0900-1730 hrs

One-day course for CICM primary examination candidates
Small class size
Focus on study technique, exam preparedness & topics of difficulty
Includes draft written questions and mock viva stations

COST: $400

2 streams:
- Primary exam candidate stream
  for CICM primary exam candidates
- Primary exam coordinator stream
  for departmental CICM program coordinators

Faculty
Primary examiners, recent successful candidates, intensivists and senior registrars

ANZICS House
10 Ievers Terrace, Carlton VIC 3053

For more information please visit vpecc.weebly.com
Register at: vpecc.eventbrite.com.au
#vpecc  @vpeccteam
The PricE Committee has continued to move forward in a number of areas. These areas include the development of new MBS items, workforce surveys and improved access to PricE Committee activities.

**MSAC AND MBS ITEMS**

The changing nature of Intensive Care practice has not kept pace with the MBS items. Currently we have no applications with MSAC but are in the process of developing new items for submission to MSAC. I will present progress on new MBS items numbers at the upcoming Auckland ANZICS AGM.

**SCOPE OF PRACTICE DOCUMENT – WHAT IS AN INTENSIVIST?**

The PricE Committee has been tasked by The Board to develop a Scope of Practice document. Many states are developing a Scope of Practice for medical practitioners in their individual jurisdictions. I envisage that the document will assist in discussions at federal, state and hospital levels. This document will be ratified by ANZICS and the CICM. The timeframe for completion is October this year.

**WORKFORCE SURVEYS**

The PricE survey has been carried out biannually. There is a planned repeat survey in October this year. The response rate has traditionally been ~20%, I would hope that we can do better this year. The data is important to obtain feedback from members about PricE related issues. It also assists in workforce planning. The ANZICS CORE Critical Care Resources Survey (CCR) is completed by unit directors and provides valuable information but the workforce data component can be strengthened. Members of the PricE Committee are assisting in the workforce questions. I hope these questions will be incorporated in the next survey.

**CHOOSING WISELY**

Choosing Wisely centres around conversations between doctors and patients who are informed by evidence-based recommendations. These recommendations are decided by individual colleges. I attended the RACP Evolve Forum “Choosing Wisely” as the ANZICS representative. The ANZICS and the CICM boards have decided appropriately that a joint ANZICS/CICM group will move forward in developing the methodology and the list.

**ANZICS WEBSITE AND PRICE**

The current PricE content on the ANZICS website is being reviewed. A member’s only page with information related to committee agendas, minutes, MBS items, applications with MSAC and informed financial consent will be established.

If you have any suggestion or comment please do not hesitate to contact me or a local state PricE representative.

Mark Nicholls
Chair, PricE Committee

### Price Committee Members

**Chair:** Mark Nicholls  
**NSW:** Michael O'Leary  
**WA:** Ian Jenkins  
**VIC:** Warwick Butt, Stephen Bernard  
**QLD:** Ranald Pascoe  
**WA:** Greg McGrath  
**NZ:** Ywain Lawrey  
**TAS:** David Rigg  
**SA:** Nick Edwards
The ANZICS Safety and Quality Committee has continued to work on projects with partners such as The Australian Commission for Safety and Quality in Health Care (The Commission), The College of Intensive Care Medicine (CICM) and the ANZICS Centre for Outcome and Resource Evaluation (CORE).

ANZICS and CICM are working together to develop a combined position statement on The Role of Intensive Care within Rapid Response Systems (RRS) planned for submission by the end of 2015. The steering committee has developed questions to be answered by working parties. A letter of invitation calling for nominations for members of the working parties has been distributed to regional chairs and special interest groups. In addition, the steering committee will consider applications from individuals to ensure that the most appropriate members are identified from the intensive care community. The working parties will be made up of experts in the field of RRS. The overall aim is to produce a high quality document which will provide guidance for intensive care units across Australia and New Zealand in the provision of care to the deteriorating ward patient.

The Committee has commenced conversations with key stakeholders in regards to the feasibility of a national Rapid Response Team Database. The Committee is aiming to conduct a survey to determine the level of support for such a database, gain an understanding of RRT variables currently collected and to determine what ANZICS members believe a minimum data set should include.

The 2015 Safety and Quality Conference: The Deteriorating Patient was held at the purpose built conference centre at Sea World on 6 – 7 July. It was a pleasure to welcome guest speaker, Dr Mike DeVita, inaugural President of the International Society of Rapid Response Systems. The Conference was an overwhelming success with 322 delegates attending and a record number of 43 abstract submissions.

The Conference included practical sessions on Rapid Response Team Training as well as covering topics on strategies to prevent rapid response team calls and a popular session on the role of Rapid Response Teams and end of life care. The organising committee is currently editing recordings taken during the 2015 Conference, in anticipation that these will be made available via You tube. Further reports and outcomes from the conference will be made available in due course. You may have also seen the publication resulting from the 2014 Safety and Quality Conference Jones et al, Findings of the first ANZICS conference on the role of intensive care in Rapid Response Teams Anaesth Intensive Care 2015; 43:369-379 which provided a summary conference.

ANZICS and the International Society of Rapid Response Systems will host the 12th International Conference on Rapid Response Systems and Medical Emergency Teams in Melbourne on May 2 – 3, 2016. It is anticipated that this International Conference will have three distinct themes – state of the art RRT, nursing issues and addressing systems and processes of care. It is early in the program planning stage but it is anticipated the key concepts will cover areas of paediatrics, obstetrics, end of life care, medical and nursing raining, and linking with administration, governance and quality improvement.

The Committee has started adding useful and practical links to the Safety and Quality pages of the ANZICS website. The aim is to assist you in optimising the safety and quality in your unit. If you have further suggestions please do not hesitate in sending them through.

Thanks to everyone who has contributed to all things Safe and of high Quality.

Angus Carter
Safety and Quality Committee Chair

S&Q Committee Membership:
Angus Carter (QLD) (Chair)
Ian Seppelt (NSW)
Krishna Ponasanapolli (WA)
Jonathan Barrett (VIC)
Krishna Sundararajan (SA)
Deborah Tooley (TAS)
Alex Kazemi (NZ)
David Schell (Paed)
Deepak Bhonagiri (Immediate Past Chair)
Mary Pinder (CICM)
Bernadette Grealy (ACCCN)
INTENSIVE CARE FOUNDATION NEWS

Book Now For The Foundation’s 2015 Masterclass!

STRATEGIES TO IMPROVE OUTCOMES IN ICU

SkyCity Conference Centre, Auckland, New Zealand
Wednesday, 28 October 2015, 1–5pm

Internationally renowned A/Prof Jack Iwashyna from the University of Michigan will head up a list of impressive speakers exploring:

- ICU and the cost of survivorship
- Bones and the effect of critical illness
- Mechanical ventilation
- Oxygen targets – the sweet spot
- Wake up and walk
- Obesity in ICU

This stimulating, interactive afternoon, chaired by Dr Gillian Hood, will conclude with a panel discussion.

Speakers: A/Prof Jack Iwashyna (University of Michigan); A/Prof Glenn Eastwood (Austin Hospital); Dr Carol Hodgson (ANZIC-RC); A/Prof Peter Kruger (Qld); A/Prof Neil Orford (Director of ICU, Geelong Hospital); Prof David Tuxen (The Alfred).

Registration fee

AUD $110 (no GST) per delegate (includes light lunch)

The Intensive Care Foundation gratefully acknowledges Covidien, sponsors of this masterclass. Funds raised through registration fees will assist the Foundation in funding ICU investigator-driven research.

For full program details please visit our website www.intensivecarefoundation.org.au

COVIDIEN

Intensive Care Foundation
...we save lives
To: Surviving Sepsis Campaign Guidelines Revision Sponsoring Organizations  
From: Laura Evans, MD, and Andrew Rhodes, MD, SSC Guidelines Revision Committee Co-chairs  
Subject: Update on Guidelines Revision  
Date: April 1, 2015  

As the Surviving Sepsis Campaign guidelines revision process moves ahead in earnest through the efforts of the Society of Critical Care Medicine and the European Society of Intensive and Critical Care Medicine, we want to thank you for your involvement in this effort and initiate regular update communications with you so you may keep your members informed through your society media. Your representative will no doubt be able to provide more information regarding his or her involvement should you wish that for your leaders and members.

A meeting of the entire panel was held during the Society of Critical Care Medicine’s Congress in Phoenix in January to set out the methodology and timeline for the 4th edition. All panel members had an opportunity to meet their colleagues and discuss the revision plan. Panel members have been assigned to one of five groups—metabolic, adjunctive therapies, ventilation, infection, and hemodynamics—under the direction of a group head. The group heads met on March 17 during the ISICEM meeting to review the PICO questions their panel members had submitted. Methodologists representing GRADE have been assigned to each group to advise as the panel members finalize PICO questions; complete literature searches; and identify, extract, and grade evidence to make recommendations for their respective topics.

The anticipated timeline calls for the groups to present a first draft during the ESICM meeting in October 2015 followed by review by the societies in late Spring 2016 with intended publication in late 2016.

We look forward to your continued interest and participation.
Paediatric Report

Paediatric Committee

Work has been underway over the last year to rejuvenate the ANZICS Paediatric Committee. The Committee provides a forum for discussion of topics pertinent to paediatric ICU and a means to ensure paediatric representation on various ANZICS standing committees. New Terms of Reference for the Committee were ratified at last month’s Board meeting, and it is hoped that the first face to face meeting will occur at the ASM in Auckland later this year.

ANZPIC Registry

CORE staff have had a very busy few months undertaking testing of the ANZPICR CORE Enterprise Reporting System (CERS). CERS is up and running for the Adult Patient Database, and the Paediatric launch is scheduled within the next few months. This exciting development will give contributing hospitals a web-based means of submission of registry data and access to tables, figures and reports. The initial suite of on-line reports will be limited, however we anticipate that reporting capabilities will increase over the next few years.

All data have been received and finalised for 2014. Once again the number of paediatric admissions to intensive care has exceeded all previous years, with more than 11,500 admissions documented for last year. The Annual Report is being worked on and will be published in the coming months.

Requests for data and research proposals are welcomed by the Registry, and the last 12 months have seen an increase in research activity based on Registry data. The processes for application for and use of Registry data were recently revised, and will be available on the ANZICS website soon, as the CORE Data Access and Publication Policy.

Paediatric Studies Group

The Paediatric Study Group has had a busy period, having completed a number of studies and embarking on several new projects. The committee has been stable now for a number of years and has managed to oversee a period of excellent collaboration between the 8 paediatric ICUs in Australia and New Zealand. In addition, strong collaborative links have been forged with international PICU research groups and with our own CTG.

The BABY-Spice pilot study of early goal-directed sedation in PICU is currently running in 5 PICUs and has enrolled more than 50% of its proposed total patients. The results of this study, being led by Simon Erickson (Princess Margaret, Perth), will be used to inform the design of and grant application for a large randomised, controlled trial the following year.

The Hypothermia in Traumatic Brain Injury in Children (HITBIC) study has just been published and represents an excellent collaborative effort by the PSG.

Multiple other studies are in various stages of development and execution, and the output from the Group is gaining in volume and momentum. At a strategic planning day held in February, there was a lively and productive discussion about future research programme identification and development and the approach to successful and secure funding of future research.

ASM

Preparations are well under way for the paediatric section of this year’s ASM, to be held in Auckland at the end of October. Fiona Miles from Starship Children’s Hospital has been working hard on the programme and we hope to see many of the PICU community there. Professor Andy Wolf, from Bristol, and Professor Martha Curley, from Philadelphia, will be the Paediatric Keynote speakers.

Johnny Millar
Chair, ANZICS Paediatric Committee

Paediatric Committee Members:
Chair: Johnny Millar
WA: Simon Erickson
SA: Michael Yung
NSW: Marino Festa
NSW: Andreas Schibler
QLD: Tony Slater
NZ: John Beca
NZ: Gabriel Nuthall
S&Q: David Schell
New Zealand

I am delighted to announce that the New Zealand ANZICS 2016 Meeting will be held at the Novotel in Rotorua on March 30 – 1 April. Jonathan Albrett from New Plymouth will be Medical Convenor, with assistance from the ICU teams of the Taranaki, Rotorua and Bay of Plenty. The theme is “Should I stay or should I go?” with some useful perspectives on the interactions between secondary and tertiary units and discussion of our transport and retrieval systems to be expected. Also, this will be the first combined NZ ANZICS meeting with the newly-formed New Zealand College of Critical Care Nurses. This should provide an excellent setting for meeting, working and learning together as well as a great reason for celebration!

The NZ branch of the Intensive Care Network was set up earlier this year, aided by a grant from the NZ ANZICS funds. The second event was held in Auckland with a presentation by Mark Thomas, an Infectious Diseases Physician entitled: “My ICU patient has HIV: Is this the end... or just the beginning?” This meeting has already expanded to 30 delegates and with your continued support will grow in size and hopefully travel around the country. Podcasts of events are expected soon on the ICN website.

The 40th ANZICS ASM, “ICU – Under Pressure” will be held at SkyCity in Auckland on 29th – 31st October. Alex Kazemi and Nic Randall are the Medical Convenors with Debbie Massey and Alison Pirret the Nursing Convenors; Fiona Miles and Nicola Gini are the Paediatric Convenors. Speakers include engineer and former NASA astronaut James Bagian and journalist Rod Oram as well as many eminent doctors, nurses and other medical professionals from New Zealand, Australia, Europe and the USA. Early registration discounts end on Monday 17th August so, if you’ve not already done so, get your leave requests in and get your registration and accommodation bookings done soon. We look forward to seeing many of you there for what will be a great ASM.

Ben Barry
Chair, NZ

Committee Membership:
Chair: Ben Barry
Vice Chair: David Knight
Secretary: vacant
Treasurer: Nic Randall
Abstract Review: Paul Young, David Knight, Ben Barry
CTG: Shay McGuinness, Colin McArthur
CORE: Peter Hicks
Price: Ywain Lawrey
DODC: James Judson, Stephen Streat
Safety and Quality: Alex Kazemi
Queensland

I had mentioned in my report in the previous edition of the Intensivist that the Labour Party which is in power in Queensland had promised before the election that they will remove individual SMO contracts and reinstate collective bargaining and access to the Queensland Industrial Relations Commission.

On 7 May 2015, the Treasurer, Minister for Employment and Industrial Relations and Minister for Aboriginal and Torres Strait Islander Partnerships introduced the Industrial Relations (Restoring Fairness) and Other Legislation Amendment Bill 2015 into the Queensland Parliament. This bill was passed on the 4th June 2014 with some amendments.

The policy objectives of the bill as follows.

1. Restoring Fairness for Government Workers', by:
   a. reinstating employment conditions for Government workers that were lost as a result of changes to the Industrial Relations Act 1999 (IR Act) made in 2012 and 2013;
   b. re-establishing the independence of the Queensland Industrial Relations Commission (the Commission) when determining wage cases;
   c. returning the Commission to its position as a layperson’s tribunal where employees and union advocates operate on a level playing field with employers; and
2. Restoring the ability of industrial organisations and their representatives to freely organise and access members so as to enhance and protect their industrial interests.

While ASMOFQ will be negotiating the new EB agreement, the concerns remain amongst the SMOs in general and ICU specialists in particular that there may be expansion of definition of ordinary hours to include evenings, overnights and weekends. The major risk is that ICU specialists will be used in the role of hospitalists without any additional payments or overtime. These concerns are being conveyed to ASMOFQ. We will keep the membership informed about how the EB negotiations progress and the implications of the final agreement.

Rajeev Hegde
Chair, QLD

New South Wales

Following the meeting of the Regional NSW Committee there was a general consensus that the focus of regional meetings be on ‘business of medicine’ events and visitors of note. The previous meeting formats have variable attendance. The NSW intensive care medical education is an incredibly full market and there are many courses and training opportunities. The trainees have training in the form of in-house teaching, the Sydney Intensive Care Long Course, SMACC and the Intensive Care Network. Consultants for the most part when not clinically working are focused on balanced lives. There was agreement that the educational focus should be in topical local affairs, professional affairs, remuneration, financial discussion, advocacy and workforce. There will always be merit in the occasional visiting speaker.

The first regional meeting was on the 14th of May 2015 with an international speaker, Dr Xavier Guasch. His excellent presentation on “Brain Death and Organ Donation - What Can Australia Learn from Spain?” was well received. Over 20 people attended the dinner meeting which was sponsored by the NSW Organ and Tissue Donation Service. There are plans for a further 2 regional meetings and a regional committee meeting.

A strong member base increases the strength of ANZICS as an advocate for intensive care. We also need to advocate for our more junior members. We will be in contact with local hospital ANZICS members to help facilitate membership.

Please do not hesitate to contact me or anyone of the committee if you have any questions, comments or concerns.

Mark Nicholls
Chair, NSW
An appreciation for the need to plan linkages between training, workforce requirements and professional roles for intensivists has increased over recent times. Pleasingly, there have been collaborative efforts between CICM and the Society to develop an effective alignment of purpose while exploring efforts to ensure that present and future needs are optimally addressed. Additional to maintaining the highest standards of clinical performance and care of critically ill patients in our region, the working conditions, professional life, career choices and personal development opportunities for intensivists are important ongoing priorities for ANZICS.

One specific area that will require additional work is that of gender balance within our specialty. This is important beyond just ensuring all individuals are supported to reach their full potential to achieve and benefit from professional engagement as intensivists. Evidence indicates that gender balance at senior professional levels increases performance through improved governance and decision-making. While the number of women graduating from medical schools has equaled or exceeded men for quite some years, intensive care remains disproportionately dominated by males. This phenomenon exists across many specialty medical and surgical domains, however, it appears that intensive care persists in remaining less balanced in gender terms than many others. It is possible that this is in part due to training factors: few other programs require advanced trainees to perform extensive rostered night duty, onerous on-call commitments and inflexible work-arrangements. However, while such challenges might disproportionately affect women, these issues also impact on other training programs and specialties which none-the-less attract higher proportions of women into their specialty. To better understand and address these challenges will require effective exploration of the issues and some strategic planning. To this end, a group of Victorian intensivists and trainees have started an initiative to raise the profile of women in critical care and champion necessary changes in order to address gender imbalance within this specialty. The initial phase of planning a series of events has commenced and details will be made available in the near future to enable interested ANZICS members (men as well as women) to contribute. This initiative by Victorian intensivists is a great example of the drive to achieve positive change through an active involvement in professional affairs.

**Stephen Warrillow**
Chair, VIC

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**Victoria**

Committee Membership:
Chair: Stephen Warrillow
Vice Chair: Ben Gelbart
Secretary: David Ku
DODC/EOLCGW: William Silvester
DODC: Helen Opdam
S&Q: Jonathan Barrett,
Abstract Review: Ravi Tiruvoipati
Education: Sam Radford
CTG: Craig French
CTG: Neil Orford
CORE: David Pilcher
South Australia

Supporting Intensive Care education has always been a core activity for ANZICS, so thank you to A/Prof. Adam Deane for inviting Prof. Jack Iwashyna to headline our SA educational activities in June.

The inaugural Trainee Lecture Series, organised by Dr. Hao Wong, was a great success. Over 30 trainees attended a morning of presentations by Prof. Jack Iwashyna, Prof. Andrew Bersten and Dr. Nick Edwards. Thank you to all the speakers and trainees who attended, we hope to make this a biannual event utilising local expertise.

Prof. Iwashyna had a busy week giving an open lecture at the University of Adelaide, as well as judging the 8th Annual Tub Worthley Travelling Scholarship. The Travelling Scholarship, organised by A/Prof. Mary White and sponsored by Pfizer, was of the usual high standard. There were 7 registrar speakers from all the major units and Dr. Palash Kar won this year’s prize with an excellent presentation of his current research.

Thank you to all ANZICS members who made these events such a success, for those who missed Prof. Iwashyna, he will be a keynote speaker at the Auckland ASM where I look forward to seeing those of you who can make it.

Stewart Moodie
Chair, SA Committee

Committee Membership:
Vice-Chair: Ken Lee
Treasurer, Abstract Review: Adam Deane
Abstract Review Committee:
Matthew Maiden
S&Q: Krish Sundararajan
CTG: Adam Deane, Sandy Peake
CORE: John Moran
Immediate Past President:
Gerry O’Callaghan
Education: Mary White
Australian Resuscitation Council:
Stuart Baker
Price: Nick Edwards
Paediatric: Michael Yung

Trainee Lecture Series June 2015
Western Australia

Western Australia and its government are gradually learning the tough lesson of living within its means après the mining boom that has dominated the WA economy for most of the past decade or so, and cushioned, temporarily, the financial blows that arose from the Global Financial Crisis. The tertiary hospitals have had a shiny new enfant terrible, Fiona Stanley Hospital, added to the family, but the older family members are not being funded for renovations or redevelopment and the planning processes that reconfigured all of the southern half of the Perth area, obstetric services and the children’s tertiary hospital are being found wanting - some hospitals, like Fremantle Hospital being woefully under-utilised, whilst Royal Perth Hospital is significantly over-active, over budget and over census. This has implications for Intensive Care - occupancy in some ICUs is higher than predicted and staff are stretched, whilst others languish, staff resources are greater than required and training opportunities suffer - Fremantle Hospital ICU really only fulfils the CICM criteria for accreditation as a foundation training ICU.

Employment opportunities for recently qualified Fellows, current trainees and even those on fixed term contracts may be far from certain. However Western Australia has a rapidly growing and ageing population and still has a relatively modest number of ICU beds per capita compared with some other jurisdictions. Short term opportunities may be limited, but medium term the outlook is rosier.

On a much more positive note, Fiona Stanley Hospital ICU converted to petty much a paperless environment at the bedside several weeks ago, with the introduction of a MetaVision (iMDSoft) clinical information system (CIS) at each bedspace. The dedication, skill and commitment of the multidisciplinary team of nurses, biomedical engineers, pharmacists, doctors, allied health staff and IT staff who got the system configured, installed and tested in under twelve months cannot be over-estimated. Once this system is bedded down and has user acceptance, having a CIS state-wide should be the next goal.

The convening committee for the ANZICS/ ACCCN annual scientific meeting (ASM) next year in Perth has met and the programme will be taking shape in the very near future. Anthony Tzannes has agreed to be the Medical Convenor for the ASM, as well as being elected, unopposed, as the WA representative on the ANZICS Education Committee> Anthony is also the Intensive Care Network (ICN) lead representative in Western Australia - around the time you are reading this we will be holding the first combined ICN/ANZICS evening dinner meeting.

We have also recently formed a jurisdictional outlier committee under the auspices of CORE - this committee consists of a delegate of the Chief Medical Officer, the ANZICS(WA) board member and the WA representative on the ANZICS Safety and Quality Committee, and will review any putative outlier events that arise from CORE APD or ANZPICR reports. If the ICU in question is a unit where one of the committee members works, that person will be replaced by an independent delegate for the period of that review.

So, there is quite an amount of activity in Western Australia, and whilst we have a number of new, younger faces taking up the cudgel in various domains, ANZICS would welcome any enthusiast who steps forward - there is always plenty to do in the realms of research, education, safety and quality, audit and industrial advocacy.

Ian Jenkins
Chair, WA
The dominant health issue in Tasmania recently has been the restructuring the three regional “Tasmanian Health Organisations” into a single health service, a process started by the newly elected government in early 2014. A single “Tasmanian Health Service” came into being on July 1st 2015. Senior clinicians and health department staff always considered this a “no brainer” for a state with a widely dispersed population of only 500K, where three separate health services had resulted in “siloed care”, duplication, inefficiency and safety and quality concerns. Previous governments had ignored these views, effectively putting the politics over common sense.

Over the past year there was unprecedented consultation and engagement with senior clinicians from across Tasmania and across disciplines, providing advice for re-configuring clinical services. The goal is for an optimally cost effective, safe and sustainable health system. The balance between service availability, proximity and adequate case volume for safety and quality provides considerable challenges in a state with a small widely dispersed population. Clinical advisory groups (CAGs) were established for Intensive Care, Emergency Medicine and Trauma as well as the various medical and surgical specialties. These comprised senior clinicians, nurses and allied health representatives from across the state, with retrieval service input and appropriate “cross pollination” of disciplines if needed.

The Intensive Care CAG, chaired by Andrew Turner, includes state ANZICS Chair, the ICU directors and nurse managers, ICU pharmacists and physiotherapists, Director of Retrievals and an Emergency physician. The ICU CAG provided detailed advice and recommendations to government on the minimum standards for safe provision of Intensive Care, and outlined a clear set of recommendations on future resourcing, staffing, education and training standards.

In the recently released White Paper, there are encouraging changes planned for surgical, trauma and emergency services that are very likely to affect ICU demand around the state. There will probably be a net increase in demand for ICU beds at both Launceston and Hobart when all these changes are implemented, with potential for reduced demand in the North West. Whilst there is a commitment to maintain ICU services at Burnie, there are considerable challenges ahead with staffing and adequate caseload to maintain skills. We will continue to monitor the impact of these changes in all centres, and the ICU CAG will continue to meet and advise. Interesting times ahead.

David Rigg
Chair, TAS Regional Committee