LEAD ARTICLE:
By George Skowronski

Malcolm Fisher used to say that once you start being asked to give talks along the lines of ‘Whither Intensive Care’, you know you’re over the hill. The ANZICS Oration is definitely what Malcolm would call a ‘whither’ talk, but it’s a huge compliment to be asked to give it. When I look down the list of my Oration predecessors, it certainly includes many people who I looked up to and who I regarded as leaders of the specialty. So it really is a great honour to do this, and I hope I do it justice.

So what does one say in a ‘whither’ talk? The answer, from various people I asked, seems to be – whatever you like! So I thought I would focus on some of the challenges I see ahead for intensive care medicine in Australasia, perhaps with the benefit of some historical insights from some of the developments I’ve been associated with during my 35-odd years in intensive care. Some of these have already been discussed at this meeting, so I desperately hope that’s not too boring!

By way of background, I was in what I regard as the ‘second wave’ of Australian Intensivists, though if you go right back, it was perhaps more like the third wave. Essentially, the people who taught me were all self-taught. They were very smart Anaesthetists or Physicians who had learned about intensive care from the general journals, from international experience or perhaps from some of the real Australasian pioneers like Matt Spence and others of that generation. There were no conferences about intensive care, no specific journals or textbooks, no colleges – anywhere in the world. These people relied upon the training of their primary specialties, especially in the basic sciences, as well as what they could piece together from the general literature and by going overseas to places like Scandinavia, which was about the only place significantly ahead of us in this.

They fought for recognition as a specialty and for ideas such as the ‘closed’ ICU under Intensivist control. The ICU I started in was a much simpler place than now. There are probably only a few people left in this audience who remember the hissing and clacking of Bird ventilators and Nurses checking tidal volumes with Wright’s respirometers on lanyards around their necks. No saturation probes or end-tidal CO₂, just daily blood gases from an arterial stab. And CVP being measured in centimetres of water, with spirit levels made from suction tubing and pink mouthwash. Non-disposable transducers that the Registrar had to chemically sterilise and then flush with saline, then balance, zero and calibrate by hand. And the Dialysis Nurses, who came a couple of times a week to dialyse. And waiting a week for ‘Sir’ to find time on his list to do a tracheostomy. Swan Ganz catheters came as a major revolution. And as for things like ECMO, I wouldn’t have even dreamed that such a thing was possible.

Mine was the first generation of career-trained Intensivists. Training programs had been established by the RACP and what was then the Faculty of Anaesthetists, and there were some rudimentary teaching resources around, but we were still a non-mainstream specialty. I remember one of the more Senior Physicians in my hospital advising me as a Registrar that choosing intensive care really wasn’t a smart option, I should complete my Physician training in one of the traditional specialities like respiratory medicine, and do intensive care as a kind of hobby. And there are a number of Intensivists of my generation who did exactly that.

But slowly, that began to change. ANZICS grew, and people like me were mentored into the ANZICS Executive by more Senior people like the legendary Teik Oh.

Now, the younger Intensivists may not appreciate that the Physician-Intensivists and the Anaesthetist-Intensivists really didn’t like each other. I don’t mean personally – we were a small group and we all knew each other and it was all very collegiate – but certainly professionally. And the main reason behind that was money. Physicians were allowed to charge higher fees. The naysayers predicted that people would be driven away from the full time public hospital mainstream into private practice, and that what were regarded as the pillars of intensive care practice – clinical excellence, teaching, research and administration – would all suffer.

That was one of my personal motives for pushing hard for an Intensive Care Clinical Trials Group. And one of the last things I did as ANZICS President was to ask Rinaldo Bellomo to take that on, and that was a choice he certainly didn’t give me any reason to regret. Of the things I’ve had a hand in, the ANZICS CTG is probably the one I’m proudest of, even though I’m not, myself, much of a Researcher.

Our success in negotiating the intensive care fees was, I think, the first real step in unifying our specialty. It was a major influence, as was this organisation, ANZICS, on the development of joint training programs and ultimately the College of Intensive Care Medicine.

The point of all this is to say to you that we were world leaders in some of these things, but they didn’t just happen. People fought hard and long for them, so you mustn’t take them for granted.

But some people were still critical of the fees. The naysayers predicted that people would be driven away from the full time public hospital mainstream into private practice, and that what were regarded as the pillars of intensive care practice – clinical excellence, teaching, research and administration – would all suffer.

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So intensive care research didn’t suffer because of the fees, quite the opposite. And ultimately we’ve ended up with a College of our own, the prospects of a reasonable private practice income, an active research group, and our clinical training is widely acknowledged. So you guys can all relax, yes? I’m afraid I don’t think so. There are plenty more big issues on the horizon, and some of you are going to have to step up, just as some of us had to. So let me now move on to some of those.

First up, futility and the aging population, undoubtedly the biggest problem we now face. We in intensive care sit right in the middle of this, we own it. We made the end of life a matter of human choice rather than a matter of fate. We changed the meaning of death – when your breathing stops you are no longer dead and when your heart stops you are no longer dead. You are dead when we say it’s time to die.

And we Intensivists have paid a very high price for that god-like power. Whereas once our ICUs were full of young people with reversible problems, now they are full of old people with many chronic co-morbidities. And yes, we still get most of them out the door, because we’ve gotten better and better at doing that. But for how long, and with what quality of life, and at what social and financial cost? If your ICU is like ours, many a coffee break is spent discussing this. Some days I finish my ward round and mentally count how many of my patients will still be around in a year. Where will it end?

Actually, I think it will end naturally, because our society will come to recognise it’s simply not sustainable. But in the meantime it’s a problem that’s much bigger than we are and we can’t, on our own, stop this tsunami of frail old people – hell, I’m going to be one of them before too long! But we, by which I mean YOU, should lead society in this debate. We need much more information, much more good data about this. Not just scoring systems, something smarter. What it’s costing, what we can achieve and what we can’t.

And we need to take that challenge back to our non-ICU Colleaguees. Why are they referring us so many of these patients? Where is the justification? Why are they so reluctant to acknowledge that the cost-benefit ratio has gone backwards? Do they expect us to do these things just because they know we can?

And why are we being so supine about it? Is it really enough to ask families if they want everything done and passively accept it when they say yes? Are people really entitled to as much treatment as they want? These are the hard questions that we need to answer and this, I think, is your biggest challenge over the next few years.

Next issue, the hospitalists and the mega-units. The two, I think, are linked. For most of my career, the typical teaching hospital ICU was 10-15 beds. In some places there were separate high-dependency areas or sub-specialty areas, most commonly for cardiac surgery, sometimes for neurosurgery. Intensivists had only minor roles in those areas, so it was fine for that kind of ICU service to have 4 or 5 FTE Specialists. Appointments to the group were infrequent and highly selective, and it was relatively easy to maintain cohesion and a uniformity of practice.

But then 3 things happened. The various procedural sub-Specialists, of whom there became more and more, got smarter. Increasingly, things that once required admission could be done as day cases or outside the hospital altogether. I myself have been the grateful beneficiary of some of those advances. The procedural doctors essentially left the hospital along with their patients, maintaining the links only for the occasional more difficult case.

At the same time, the economic rationalist movement invaded hospital management, and managers became much more powerful than doctors. We were reduced to ‘health care workers’ or, even worse, ‘human resources’ – a description I hate with a passion. Now it was all about efficiency and savings. Hospitals were businesses. No-one remained in the hospital a moment longer than they absolutely had to. And thirdly, there came this growing cohort of elderly people with multiple complex co-morbidities. And they were the ones who filled the hospital beds, because they couldn’t be treated elsewhere. And, for us, the Intensivists, this perfect storm came together with Ken Hillman’s work on Medical Emergency Teams. The hospital was full of these complex elderly patients, the General Physicians had almost become extinct, and the only people who were still available and who really knew how to manage these patients were the Intensivists. And so we saw the increasing development of intensive care ‘outreach’ and, ultimately, the ‘mega-unit’ – a dozen or more Intensivists running ICUs of 40-60 beds as well as a variety of outreach services.

“Great!” I hear you say, “now our importance as a specialty has finally been recognised. ICU Directors now rule vast empires!” But it’s come at a great cost. I think we’ve lost a lot of the cohesion that once made us the envy of the world. The ‘closed ICU’ that our predecessors fought so hard for is being progressively diluted by more and more sub-speciality consults. And most of our time is no longer spent on the management of critical illness and vital organ support, but rather on perioperative and high-dependency medicine. Our primary skills are being diluted.

Solutions? Well it’s over to you guys. Maybe we need to return to our roots and retreat to ‘real’ critical care again, while others do some of this general medicine. A reincarnation of the General Physician perhaps – which I see happening in many places. Or maybe our College needs to set up a Faculty of Hospital Medicine and begin training proper career hospitalists. It will be interesting to watch this all evolve, but again, I urge you, don’t just let it happen, play an active part. This is all about you and your future.

Another development, that I’m sure will be part of all these things I’ve been discussing, is the advent of 24/7 in-house specialist cover. It’s happening in other parts of the world, notably the US, and I think it’s already starting to appear here. I’m really glad I’ll be retired before this one hits – and I’ll take early retirement if I’m not!

Unfortunately, the logic is insurmountable – if you need an expert to manage all these complex patients during the day, how can they be managed by a Registrar at night? And if you’re going to roster the Consultants to do nights, why bother with a Registrar as well? But how will we do it? How many FTES will it take to run a 50-bed ICU plus outreach service on a 24/7 basis? How will you roster it?

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How often is it fair to roster a Senior Intensivist on nights in-house? What about when you’re 65 years old? If infrequently, what duties will they do in between? Or will we have more time off? And the impact on health and family life? And can you still be regarded as a Senior professional if you’re a shift worker? And how much should you expect to be paid for doing that? Let me tell you, I’d want a bloody lot!

Of course, there are lots of Nurses here, and Nurses have always been shift workers. There’s another whole debate about the impact of that on their profession, but I’ll leave that for someone else, because otherwise I’ll get myself into trouble very quickly.

So instead, let me get myself into even deeper trouble, much closer to home. This is a bit of an elephant in the room and I think it will make a few people uncomfortable. But someone needs to say it. History and politics teach us that a ‘President for life’ is a bad thing. They tend to become despots and generally end up doing their countries and their people a lot of harm, even if they started with the best of intentions. Julius Caesar, Napoleon, Kim-Il-Sung, Bashar al Assad, the pattern is the same. They all came to believe their country was their personal possession. They built it, they organised its success, only they had the vision to carry it forward. Only they could decide when to step down – or maybe never…

And unfortunately, so it is with some ICU Directors. Some have simply stayed on well past their use-by date, causing frustration among their Collegeagues. And a few have been ousted in a coup. But that’s not the worst of it. Over the last decade or so, I’ve had a number of ex-Trainees, now in mid-career, come back to me in great distress, having been victimised or having suffered from vengeful or capricious treatment from their ICU Directors. Some have simply stayed on well past their use-by date, causing frustration among their Collegeagues. And a few have been ousted in a coup. But that’s not the worst of it. Over the last decade or so, I’ve had a number of ex-Trainees, now in mid-career, come back to me in great distress, having been victimised or having suffered from vengeful or capricious treatment from their ICU Directors. Often this is in response to perceptions of disloyalty or a threat to the Director’s authority. And it’s always in ICUs where one person has been the Director for many years, often having been appointed to the position as quite a Junior Specialist. And while they may rule with an iron fist, they have no real insight into their behaviour and its consequences. They continue to believe they are just doing what’s best. In Bill Runciman’s words, they have come to believe their own bullshit.

Because public hospitals are part of the public service, life tenure is still possible, unlike anywhere else in modern society. And because these people are always empowered and supported by the rules and by their hospital administration, their victims find themselves powerless to respond.

These disputes are common in our specialty; they can be very damaging, very bitter. Units that suffer from these problems tend to go backwards, losing those good characteristics which previously set them apart. People become disengaged, uninterested and burned out. It’s quickly picked up by the juniors and the word gets out, affecting recruitment.

Tenured appointments may have been reasonable back when hospitals had only one or two trained Intensivists and our society was generally more hierarchical, but I suggest it isn’t appropriate now. ICU Directors should have limited tenure, and they should be first among equals, in a collegiate rather than a hierarchical structure. Like an ANZICS President or a College President.

I think we need to stand back and think a bit more deeply about how we work as groups of professional Collegeagues and how we do our succession planning. Maybe ANZICS or the College, or both, need to take a position on this. Maybe they need to provide mediation for some of these problems, but only if the mediators have teeth. Otherwise it’s a waste of time.

Finally, and in a way it’s related, I want to say something about our mental health and our families. It seems to me we don’t have a very good track record in this regard. I’ve seen lots of people leave intensive care disillusioned, lots of divorces and even a few suicides. I’m one of the lucky ones; my wife Lorraine and my 3 now adult children, of whom I’m inordinately proud, have been my rock and my sanctuary through the ups and downs, of which there have been a few. I’m not sure I would have got to this point without them.

So, this job that we do is rewarding, stimulating and absorbing, but don’t let it be your life. Look after yourselves, your families, each other.

And last of all, make some time to give something back. Stand up, have your say, mould our specialty for yourselves and for the next generation of Intensivists. If you’re like me, you’ll find that the most rewarding part of your career.

Thank you,
George Skowronski

What about when you are 65 years old? And if infrequently, what duties will they do in between? Or will we have more time off? And the impact on health and family life?"
Key dates for 2016:

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<td>Abstract submission open</td>
<td>March 2016</td>
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<td>April 2016</td>
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<td>Abstract submission deadline</td>
<td>July 2016</td>
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The Women in Intensive Care Medicine Network (WIN) is a new organisation dedicated to addressing the gender imbalance within our speciality through advocacy, research and networking and mentorship opportunities. WIN was founded in Melbourne by a group of Intensivists and Trainees, and now has Representatives in Sydney, the Gold Coast and Adelaide. Our vision is to improve the representation of women in all facets of intensive care medicine – clinical, academic and leadership.

WIN held its inaugural dinner on 13th October at Hellenic Republic in Kew. This was a hugely successful event with over 30 attendees representing 10 ICUs in Victoria. Dr Helen Opdam (Senior Intensivist, Austin Hospital and National Medical Director of the Organ and Tissue Authority) and Dr Deirdre Murphy (Director of Cardiothoracic ICU at Alfred Hospital) spoke with great humour and insight about the challenges facing women working in ICU. These talks provided fuel for robust discussion throughout the evening.

One of the clear themes to emerge from our discussion is that gender imbalance in ICM is not simply about babies, family or domestic responsibilities. Many male Intensivists have significant parenting and domestic responsibilities. Some female Intensivists do not want children and for those who do, family life is not the only factor affecting their career advancement. Improving the gender balance within our speciality will require cultural change. Our specialty has a great deal to gain from having more females in Consultant and leadership roles. Several guests spoke passionately about the strengths of female Intensivists. And the benefits of workforce diversity are not confined to gender diversity – ICM would benefit from greater diversity of ethnicity, religion and sexual orientation in the workforce too.

The inaugural WIN dinner was both inspiring and great fun, generating enthusiasm for future events. We would like to thank ANZICS, in particular Dr Stephen Warrillow, for their ongoing support of WIN and for helping to secure sponsorship for this event. We thank IKARIA for having the foresight to sponsor this important evening. Thank you for Timothy Morrison of Timson photography for capturing some great images of the evening. Finally, we would like to thank the Intensive Care Network, especially Dr Gerard Fennessy and Dr Oli Flower, for their support with both organising this event and hosting our website.

Written by:
Lucy Modra, Sarah Yong, Tamishta Hensman

First, we considered the low percentage of women in ICU Consultant and leadership positions such as Board memberships. The increasing proportion of female intensive care Trainees is promising, but we need to actively work to ensure this translates to a more balanced ICU workforce in the future.

Both speakers discussed unconscious gender biases and how these affect women’s career progression. Unconscious gender schemas, internalised by both men and women, have been repeatedly demonstrated to decrease a woman’s chance of success in applying for a job or promotion. This occurs even during seemingly ‘objective’ processes like assessing a CV. Moving into senior positions in Intensive Care Medicine (ICM) is often relies on a ‘tap on the shoulder’- and this may further increase the risk of unconscious bias. We discussed the issue of self-confidence, including evidence that women tend to under-estimate their abilities and competence whilst men tend to overestimate them. This ‘confidence gap’ may be particularly important in ICM given that it is a competitive speciality that deals with high-risk patients and interventions. Several Intensivists reported that leadership and/or performance training was incredibly helpful to their confidence and career progression. Therefore, WIN will develop a women’s leadership training symposium in 2016.

This led to the controversial issue of ‘tokenism’ or quotas to address gender imbalance. Women don’t want to feel that they have been selected to fill a quota or to be the ‘token woman’, as this may call into question their merit for the role. However, if we take seriously the evidence regarding gender biases, we must accept that sometimes men are selected for a position partly because they are male. This makes systems in which women are selected for positions partly because they are female seem more acceptable and fair.

Combining intensive care medicine with parenting was identified as a key challenge for women. Several mothers shared their strategies for successful juggling, and many highlighted the importance of opportunities to work part-time. Domestic and caring responsibilities have a significant impact on women’s career progression. Some women described how difficult it is to travel for conferences or training courses with young children. Of course, these issues affect fathers too. Increasing workplace flexibility and opportunities for part time work will benefit all Intensivists- male or female, parents or not. Providing flexible roster options for all ICU doctors whilst ensuring continuity of patient care is an important challenge for the future.

The Intensivist - December 2015
Dear Membership of ANZICS,

Firstly I would like to express how honoured I am to serve this esteemed membership and craft group as President of our Society. I have been serving on the ANZICS Board since 2008 and held Executive positions for the last three years. My thanks go to the outgoing President Andrew Turner for his valuable contribution and drive to promote the Society. Thanks also to Mr Justin Williams, retiring ANZICS CEO who has steered the ANZICS office in Melbourne extremely efficiently.

I would like to extend a warm welcome to Mr Tony Tenaglia, the new General Manager of ANZICS who comes with impeccable credentials to help us further the ambitions of ANZICS. Unbeknownst to many, it is the staff at Ievers Terrace in Melbourne that keep the Society moving forward and progressing with the times. I would like to extend my thanks to them for past efforts and look forward to a collegial and effective time as President working with the ANZICS staff.

Having been elected at the Annual General Meeting in Auckland on the 30th October 2015, it was very humbling to be endorsed by such widespread representation of the membership. Dr George Skowronski’s excellent Oration indirectly lay down a mandate for ANZICS and its activities in the near future. As President, my plan is to consolidate the current excellent initiatives that are being run by ANZICS such as the PricE, CTG, DODC, CORE and Education Committees and End of Life Care Working Group. We have to embrace the fact that our Society must change to accommodate imposts on our craft group, such as the Hospitalist and other ICU outreach concepts (MET/Rapid Response Systems). We will strive to expand the membership of the Society in general, and both CORE and CTG memberships. In Auckland I quoted Henry Ford: ‘If you always do what you’ve always done, you’ll always get what you’ve always got” – I believe that this is a very true statement and change in life is inevitable. Change can be uncomfortable if it is enforced upon you, but if you are able to mould and influence the change, it is something very beneficial. A new ANZICS initiative is the Communications and Social Media Working Group, an Education sub-Committee of ANZICS being led by Peter Harrigan, which will be focusing on making ANZICS more accessible and more visible in the Intensive Care sphere especially in our two great countries but also globally. We also look forward to a multitude of high quality future ANZICS conferences and we will be the proud and successful hosts of the World Federation Conference to be held in Melbourne in 2019.

Financially I will work with the General Manager and Board towards introducing business and governance structures that will better protect the Society from financial risk and also make prudent investments in projects to ensure the Society’s viability into the future.

The Choosing Wisely Campaign Survey was well received with a good response rate. The final choices of the ANZICS membership and CICM Fellowship respondents will be published soon.

ANZICS, for its size, delivers results and products that far exceed those of similar societies. A lot of the ANZICS membership provide pro bono work to sit on and promote the activities of the Committees. I encourage all members to get actively involved with ANZICS initiatives. ANZICS is globally recognised as a leader for the advocacy of Intensive Care Medicine.

“Together we are greater than the sum of our parts”.

Dr Marc Ziegenfuss
President, ANZICS

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**ANZICS BOARD MEMBERS 2015/2016**

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<td>Immediate Past President</td>
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<td>Paediatric Chair</td>
<td>Johnny Millar</td>
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2015 ANZICS/ACCCN Annual Scientific Meeting Medical Prize Winners:

Best Medical Poster
Ms Maria Cronhjort
“Are Fluids Harmless?”
Sponsored by

Best Paediatric Medical Paper
A/Prof Luregn J Schlapbach
“Exome Sequencing Reveals Underlying Primary Immunodeficiencies in Children with Fulminant Community-Acquired Pseudomonas Aeruginosa Sepsis”
Sponsored by

Best Allied Health Paper
Mrs Amy Freeman-Sanderson
“An Intervention to Allow Early Speech in Ventilated Tracheostomy Patients in an Australian Intensive Care Unit (ICU): A Randomised Controlled Trial”
Sponsored by

ANZICS Intensive Care Global Rising Star Programme
Sponsored by

Safety & Quality Best Paper
Dr Ling Li
“Clinical Work Patterns of ICU Registrars – A Multi-Site, Time and Motion Study”
Sponsored by

Best Medical Free Paper
Dr Adam Deane
“Pantoprazole or Placebo for Stress Ulcer Prophylaxis (Popup) Study”
Sponsored by

European Global Rising Star
Dr. W. Joost Wiersinga
“The Role of the Gut Microbiota in the Host Defence Against Pneumonia Derived Sepsis: Towards New Treatment Strategies in the Critically Ill”
Sponsored by

American Region Global Rising Star
Assistant Professor Hallie C Prescott
“Early and Late Attributable Mortality of Severe Sepsis”
Sponsored by

ANZICS Matt Spence Medal
Dr Palash Kar
“Personalized Glycemic Control in Critically Ill Type-2 Diabetic Patients: An Exploratory Study”
Sponsored by

Ramesh Nagappan
Education Award
Dr Cameron Knott
Sponsored by
2015 ANZICS/ACCCN Annual Scientific Meeting Medical Prize Winner Gallery:
The New Zealand Regional ANZICS Meeting
30 March - 01 April 2016, Novotel Rotorua Lakeside, New Zealand
http://www.anzics-nzasm2016.nz

18th Annual Meeting on Clinical Trials in Intensive Care
08 - 10 March 2016, Sheraton Noosa Resort
http://www.anzicsctg.org

12th International Conference on Rapid Response Systems & Medical Emergency Teams
02 - 03 May 2016, Melbourne

CTG Winter Research Forum
1-2 August 2016, Sydney, Australia
http://www.anzicsctg.org

ANZICS/ACCCN Critical Care Collaborative
Friday 26 August 2016, Rydges Hotel, Carlton

ANZICS/ACCCN ASM
20 - 22 October 2016, Perth
MEMBERSHIP REPORT

Since the last edition of The Intensivist we are pleased to announce we have gained 26 new Members. 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. 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.

Following the AGM in Auckland, I’d also like to announce the change in the ANZICS Membership categories. Affiliate and Associate Members will be replaced with; Nurse, Allied Health, Research Coordinator and Overseas/Retired. The category changes were designed to specify and embrace the other professions that contribute and help shape the Intensive Care Community. The Society has also recognized the need to embrace the enthusiastic young Trainees in the profession, and has begun amending the various Committees to allow a Trainee Representative on every standing ANZICS Committee. Trainee Members are invaluable in representing the views of the younger group of Specialists and are also the next generation of ANZICS leaders. The Trainees will form their own Committee and elect a Representative from within the group to sit on the ANZICS Board and represent all Trainees of the Society.

Expressions of interest for these roles will be circulated in the coming weeks, I encourage all Trainees to become involved with ANZICS and submit interest to the Committees.

Although we have always been successful in recruiting new Members, I must encourage all ANZICS Members to continue promoting 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 Societies 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.

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. A reminder to all Trainees receiving their CICM Fellowship, discounted incremental rates have been introduced to recognise the transition into an ICU Consultant position. Please see the ANZICS website for full details and prices.

Simon Erickson,
Hon Secretary

Please welcome the following new members:

- Benjamin Hew
  Lismore Base Hospital, NSW

- Pei Ling Ng
  Adelaide Women’s and Children’s Hospital, SA

- Mark Woolley
  CCDHB, Wellington Hospital, NZ

- Liam Byrne
  The Canberra Hospital, ACT

- Ali Haji Vahabzadeh
  The University of Auckland, NZ

- Jonathon Fanning
  Queensland Health, QLD

- Alastair Carr
  Dunedin Hospital, NZ

- Anna Mulvaney
  Auckland District Health Board, NZ

- Mohammed Ishaq Ruknudeen
  Lyell McEwin Hospital, SA

- Jennifer Jones
  Austin Health, VIC

- Martin Christensen
  Queensland University of Technology, QLD

- Stephen Fowler
  Royal Darwin Hospital, NT

- Tim Byrne
  The Alfred Hospital, VIC

- Andrew Greer
  Christchurch Hospital, NZ

- Rebecca Pearce
  Starship Hospital, NZ

- Victor Birioukov
  Auckland City Hospital, ADHB, NZ

- Judy Currey
  The Alfred Hospital/Deakin University, VIC

- Kathryn Tietjens
  Wellington Hospital, NZ

- Anna Green
  Western Health, VIC

- Mark Savage
  Peninsula Health, VIC

- Logan Marriott
  Wellington Hospital, NZ

- Lyndal Russell
  The Prince Charles Hospital ICU, QLD

- Melissa Kaufman
  Eastern Health, VIC

- Christopher James
  Royal Children’s Hospital, VIC

- Patryck Lloyd-Donald
  Austin Health, VIC

- Rachel Crawford
  Joondalup Health Campus, WA
The ANZICS CORE Reporting Portal – Adult and Paediatric reports now available!

The largest single IT project ever undertaken by ANZICS has just completed its first phase with the adult and paediatric reports now both available through the ANZICS CORE Reporting Portal. A combination of tables and figures allow you to look at mortality outcomes, readmissions, after-hours discharges, length of stay and much more……….all in a format where you can compare your ICU to similar hospitals, pick any time period of interest, examine major diagnostic groups such as medical, surgical, sepsis or trauma, and compare by source admission to your ICU (ED, operating theatre or ward).

Please use your data and look at your reports. If you don’t have access, send us an email and we will set it up (we just need the OK from your ICU Director). For more information please contact sue.huckson@anzics.com.au

AORTIC – under redevelopment now

AORTIC is the software program used by the majority of ICUs in Australia and New Zealand to collect data to send to CORE. Provision of this free software to ANZICS members is one of the main reasons for the success and coverage of the registry over the past 20 years. However soon the platform on which it is built will no longer be supportable by many of the windows based IT systems in ANZ hospitals. Development has just begun on a new data collection system which will almost certainly need a new name too! The aim is to replace AORTIC with something better which will have more flexibility and capacity for future development. However, this will take time and work. In addition, shortfalls in funding from Queensland and New Zealand may lead to delays in implementation within these regions. Watch this space for more information in coming months.

Feedback from the ANZICS ASM in Auckland

Thanks to the Organising Committee for a great ASM, and for supporting CORE with two sessions. The first showcased some of the research work coming out of CORE, with presentations from Jack Iwashyna about persistent critical illness, Luregn Schlapbach on paediatric sepsis outcomes, me (presenting on behalf of Tim Coulson) about how a change in mortality risk between the pre-operative and post-operative periods might facilitate comparison of cardiothoracic surgical units and Peter Hicks presenting on the costs of ICU in Australia and New Zealand.

The second CORE session ‘unpacked the CORE mystery box’. Chaired by David Ku, this lively interactive session provided practical information on ANZICS CORE activities and how to get involved.

Trainee Representation and Involvement in CORE

Are you a Trainee who is interested in big data?
Do you care about quality in the ICU and how we might measure it?
Do you want to know more about how we can compare one ICU to another?

There are a number of ways for Trainee to get involved with CORE – from analysis and write up of data for formal projects, to assistance with IT development and all ideas are welcome! However we will also soon be looking for a Trainee to join the CORE Committee. Consider becoming part of ANZICS CORE and contact Sue (ANZICS CORE Manager) at sue.huckson@anzics.com.au

Dave Pilcher and the ANZICS CORE Management Committee

CORE Management Committee:

David Pilcher - Chair
Johnny Millar - Chair, ANZPICR
Peter Hicks - Chair, CCR

The Intensivist - December 2015
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CLINICAL TRIALS GROUP (CTG)

The CTG continues to fulfil its mission of “promoting excellence through collaborative clinical research”. In early October, coinciding with presentations at the European Intensive Society of Intensive Care Medicine meeting, three large pragmatic randomised controlled trials were published in leading medical journals: SPLIT (balanced electrolyte versus 0.9% saline) in JAMA; HEAT (paracetamol for fever in critically ill patients) in NEJM; EPO-TBI (erythropoietin in traumatic brain injury) in the Lancet. I am not aware of any other trial group, in any other discipline, that has achieved what is effectively simultaneous publication in the world’s three leading clinical medicine journals.

Elections for Regional Representatives were recently completed. I welcome Andrew Udy (Victoria), Jeremy Cohen (Queensland) and Paul Young (New Zealand) to the CTG Committee. I also thank Michael Reade, Neil Orford, and Shay McGuinness for their contribution as Committee members and look forward to their ongoing involvement in CTG activities. Following Racheal Parke’s election to Secretary Glenn Eastwood has joined the Committee as the IRCIG Representative.

Our spring research forum was truncated to a half day meeting to facilitate an “Intensive Care Masterclass” organised by the Foundation. Highlights of the meeting included the presentation of the results of the IRONMAN (iv iron in anaemic critically ill patient) study and the final version of the BLING III (intermittent versus continuous infusion of intravenous antibiotics) protocol. While some initial concern existed as to the near concurrent CTG and Foundation activities both meetings were successful. This provides an opportunity for the CTG and Foundation to consider future joint activities – particularly in association with the ASM. In early November the results of the latest National Health and Medical Research Council (NHMRC) funding round were announced by the Minister of Health Susan Ley. I am pleased to report that CTG endorsed studies were again successful in securing major project grants. PLUS is a randomised controlled trial evaluating the effects of a balanced electrolyte solution versus 0.9% saline in critically ill patients. The trial’s chief investigator is Professor Simon Finfer and trial management will be provided by the George Institute for Global Health.

Over six million dollars was awarded to conduct this trial. OPTIMISE-CAP (community acquired pneumonia) was also funded for over three million dollars. This is the first time the NHMRC has provided substantial funding for a “platform trial”. The trial’s chief investigator is Clinical Professor Steve Webb and it will be managed by the ANZIC-RC. Platform trials are a new methodology that will be presented and discussed further in Noosa next year. The funding of these studies ensures CTG member units will have access to participate in high quality multicentre research for the next five years.

The 18th Annual Meeting on Clinical Trials in Intensive Care will be held in Noosa for Tuesday 8 March until Thursday 10 March 2016. In addition to the main meeting there will be satellite IRCIG, CORE, PSG, and basic science meetings. An engaging and stimulating program is being developed. I look forward to welcoming members of the CTG community to Noosa next year.

Craig French
Chair, CTG

Committee Membership:

Chair: Craig French
Immediate Past Chair: Colin McArthur
Vice Chair: Sandra Peake
Treasurer: David Gattas
Secretary: Racheal Parke
NSW/ACT: Manoj Saxena
NZ: Paul Young
QLD: Jeremy Cohen
SA/NT: Adam Deane
TAS: David Cooper
VIC: Andrew Udy
WA: Ed Litton
IRCG: Glenn Eastwood
PSG: Simon Erickson
CORE: David Pilcher

Gain access to software, central processing and reporting facilities inclusive of; the Annual Scientific Meeting, the ANZICS Safety & Quality Conference, Singapore-ANZICS and other smaller inclusive of comparative reports on adult patient activity specific issues and information for all ANZICS Members.

Share in and contribute to the professional profile and identity of Intensive Care Specialists in the healthcare and broader community.

Become an ANZICS Member today for a great range of benefits including:

• Access to software and reporting facilities provided leadership in medical settings, clinical research and analysis of critical care resources.

• Contribution to the Intensive Care Community: provision of leadership in medical practice through ongoing professional education, the

• Access to exclusive email lists:

• Discount to ANZICS Conferences:

• Free subscription to regular email updates on Intensive Care specific issues and information for all ANZICS Members.

•  Discount to ANZICS Conferences:

The Society is devoted to all aspects of intensive care matters. The Society is the leading advocate on all intensive care related Global Health.
DODC Activity

2015 has been a slightly quieter year for the DODC than 2014. The Committee has provided feedback to the NHMRC regarding their consultation draft on the Ethical guidelines for Organ Transplantation from Deceased Donors. Additionally, the EOLCWG and DODC were approached by the RACP and the Transplantation Society of Australia and New Zealand (TSANZ) respectively for consultation on 2 separate documents. The New Zealand Ministry of Health have also requested ANZICS DODC engagement in a review of deceased organ donation and transplantation rates in New Zealand.

The DODC has recently published a statement on Circulatory Death Determination in response to an article on DCD heart transplantation published by the Australian Financial Review (AFR). This statement along with the ANZICS Statement on Death and Organ Donation edition 3.2 is available on the ANZICS website under Committees - Death and Organ Donation.

AOTA Activity

Some of you may be aware of the government announcement earlier this year to review AOTA’s organ donation and transplantation programme. ANZICS released a statement in support of AOTA and the organ donation and transplantation programme, which was sent to the media, ANZICS members and is available on the ANZICS website. The Chair of the DODC and EOLCWG, Bill Silvester, attended the review at Ernst and Young along with Representatives of DonateLife Victoria, the Lions Eye Bank, the Victorian Tissue Bank, a kidney, liver and thoracic transplantation, the Transplant Nurses Association, CICM. There was broad and open discussion covering many areas of organ donation and transplantation.

End-of-Life Care Working Group (EOLCWG)

The 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, Bill Silvester had the opportunity to promote the statement on Radio National’s Health report with Dr. Norman Swan as well as via a podcast with Neil Orford. Additionally, the Statement lead to the publication of an article in the Australian Hospital and Healthcare Bulletin.

ANZICS also continues to receive regular requests to reference the Statement for the development of related educational resources. It will periodically be reviewed by the EOLCWG to ensure it remains relevant and up to date and the Working Group encourages any comments or feedback to be submitted. The DODC and EOLCWG wish to thank the ANZICS membership for their vital input and support.

DODC & EOLCWG

DODC Committee Membership:

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

EOLCWG Committee Membership:

Chair: A/Prof. William Silvester (VIC)
Dep. Chair: Dr Stewart Moodie (SA)
NSW: Professor Malcolm Fisher
NSW: Professor Ken Hillman (Advisory only)
QLD: A/Prof. Brent Richards
NSW: A/Prof. Theresa Jacques, Dr Peter Saul, Dr Stephen Jacobe
NZ: Dr Stephen Streat, Dr James Judson
CICM: Dr Charlie Corke (VIC)
NT: Dr Penny Stewart
SA: Dr Dominic Wilkinson
Since the last edition of The Intensivist, the Education Committee has gained a new Chair, thank you to Stephen Warrillow for stepping into the position of Acting Chair of the Committee for the first 9 months of 2015. Also, thank you to Sumeet Rai who recently resigned from the Committee. The position for a NZ Representative is currently vacant, an EOI for this role has been circulated to NZ ANZICS members, if anyone wishes to nominate for the position please contact jessyca.menzel@anzics.com.au.

The Education Committee has had an advisory role in helping with the development and delivery of the ICE course at Eastern Health in November 2015. The Convenor, Dr Max Moser and his team have done an excellent job of putting together a practical, pragmatic, immersive curriculum. This course will allow Trainees, ideally midway through their training to safely develop their own confidence and competence in a wide range of potentially confronting scenarios.

A new working group, the Communications and Social Media Working Group (CSMWG) has been formed within the Education Committee structure. Thank you to all involved, for the enthusiasm and insight you offer into meaningful communication of the great education activities.

In 2016 the Education Committee along with the CSMWG will further develop the online education system. To date, content has been taken from a variety of areas such as past ASMs and Safety and Quality, and has been made available online. Material will continue to be added from future ASMs and events as well as from other Committees of the Society which will provide the membership with access to high quality presentations from previous ANZICS conferences.

We thoroughly enjoyed sharing in the exciting programme that the Auckland ASM team developed this year.

Sam Radford
Chair, Education Committee

Committee Membership:

Chair: Sam Radford (VIC)
Vice Chair: Stephen Warrillow (VIC)
Paediatric/QLD: Scott Simpson
NSW: Charudatt Shirwadkar, Dhaval Ghelani, Elizabeth Fugaccia, Michael O’Leary
NT: Rajendra Goud
NZ: Vacant
SA: Mary White
TAS: Andrew Turner
WA: Anthony Tzannes

Communication and Social Media Working Group:

Chair: Dr Peter Harrigan
NZ: Dr Kirsten Bond
NSW: Dr Nurdat Rashid
NSW: Dr Craig Hore
VIC: Dr Tom Rozen
VIC: Dr Elizabeth Skinner
PAEDIATRIC COMMITTEE

The Paediatric Committee is undergoing a rejuvenation and reconstitution for the coming year. Following a call for expressions of interest, a new Committee has been drawn up and terms of reference ratified by the ANZICS Board. The new Committee hopes to meet by teleconference before the end of this year.

ANZPIC Registry

A huge amount of work has been done over the last few months in preparation for the launch of the CORE Enterprise Reporting System (CERS). This web-based data submission and viewing portal will allow units to view and refine ANZPICR charts and tables at any time. Historical data has all been loaded, testing is essentially complete, and by the time that this article has been published CERS will hopefully be live and in use in contributing units. This will be a great way for units to engage directly with their data and the Registry, and we look forward to feedback from individual units.

The 2014 Annual Report has been somewhat delayed by all the work that has gone into CERS, but we hope to publish this soon. The report contains details of more than 11,000 paediatric admissions to intensive care units for the calendar year.

Several prominent publications have ensued from the analysis of ANZPICR data over the last 12 months. Requests for data and research proposals are always welcomed by the Registry, and the process for data application and use is described on the ANZICS website.

Paediatric Studies Group

The Paediatric Studies Group has had a busy few months, and is gathering significant momentum and forging important links with overseas PICU research networks.

A pilot study of early goal-directed sedation in PICU is nearing completion, being led by Simon Erickson (Princess Margaret, Perth) and Deb Long (Lady Cilento Children’s Hospital, Brisbane). The results of this pilot study will be used to inform the design of and grant application for a large randomised, controlled trial next year.

The SAFE-EPIC project looking at fluid resuscitation in PICU in more than 120 units around the world has been completed and is in the process of manuscript preparation. This impressive effort was led by Rino Festa (Westmead Children’s Hospital, Sydney). Several other prospective trials and data-gathering studies are continuing, and there are exciting new opportunities on the horizon. Simon Erickson will be stepping down shortly, having completed his tenure as Chair of the PSG, and overseen an excellent period of growth and success.

ASM

Last month’s ANZICS ASM in Auckland was a great success, with a large number of national and international contributors to the paediatric meeting. Thanks are due to Fiona Miles for her hard work in convening the paediatric stream of the ASM. We look forward to a similarly successful meeting in Perth next October.

Johnny Millar
Chair, Paediatric Committee

Committee membership

VIC/Chair
Johnny Millar

NSW
Andrew Numa

QLD
Andreas Schibler

WA
Geoff Knight

SA
Ranjan Joshi

TAS
Hamish Jackson

General ICU
Resy van Beek
Since the September report the Price Committee met face to face in Melbourne. The Price Committee have been busy on a number of fronts including the upcoming Federal Government Review of the Medicare Benefits Schedule (MBS), development of new intensive care Medicare Benefits Schedule (MBS) items, development of an Intensivist Scope of Practice Document, ongoing workforce issues and engagement with Private Health Funds.

MBS Items

As previously reported the Federal Department of Health is about to commence a review of MBS items using a rapid review process, developed in Ontario, Canada. In August, the Federal AMA held a Forum in Canberra. The aims of the forum are to have a coordinated response to the reviews and avoid payoff of one specialty against another. There will be representation from both the CICM and ANZICS.

Private Health Funds

Medibank Private’s cherry picked a list of 165 such events it calls ‘highly preventable adverse events’ for which it will not pay. My understanding is that the Australian Commission on Safety and Quality in Health Care (ACSQHC) made representations to Medicare Private that the use of the list was inappropriate. The details of the recent agreement between Medibank Private and the Calvary Group of hospitals are still not clear.

Intensivist Scope of Practice Document

The Committee are currently developing an Intensive Care Specialist scope of practice document, once completed the document will be submitted to the ANZICS and CICM Boards for review. The Price Committee is committed to improving the status of the specialty, ensuring adequate remuneration for intensive care specialists and monitoring the well-being of all Intensivists.

Any comments or concerns please speak to your local Representative on the Committee. Active involvement and engagement with the Committee will only strengthen it.

All the best in the New Year and have a safe and happy break.

Mark Nicholls
Chair, Price Committee

Committee Membership:

Chair/NSW: Mark Nicholls
Deputy Chair/VIC: Stephen Bernard
Past Chair/WA: Ian Jenkins
NZ: Ywain Lawry
QLD: Ranald Pascoe
SA: Nick Edwards
TAS: David Rigg
WA: Greg McGrath
Paediatrics: Warwick Butt
Dr Gill Hood, Foundation Chair (pictured above right with Grant recipient A/Prof David Gattas) announced grants totalling almost $250,000 at the ANZICS/ACCCN Annual Scientific Meeting gala dinner, held in Auckland on 31 October.

In announcing the 2015 Grants, Dr Hood expressed gratitude to the Foundation’s corporate sponsors Covidien/Medtronic, Fisher & Paykel and Baxter Healthcare.

A Grant was established in perpetuity to honour the outstanding contribution of the legendary intensivist Professor Malcolm Fisher, while Professor Jeff Lipman was named Fellow of the Foundation in recognition of his valuable work as Co-Chair of the Scientific Review Committee 2011-2014.

Grant Recipients and their Projects

**Parent initiated response to escalate care of the deteriorating child: the PARTNER project**
Dr Fenella Gill

**Novel methods of measuring physical function in ICU survivors**
Dr Elizabeth Skinner
*Malcolm Fisher ICF Grant*

**Induced hypernatremia - a therapy for acute lung injury? (HALT study)**
Prof. Andrew Bersten
*Fisher & Paykel Research Grant*

**A pilot study of 20% vs 4% human albumin solution for fluid bolus therapy in critically ill adults**
Dr Johan Martensson
*Baxter Healthcare Novice Research Grant*

**Levetiracetam pharmacokinetics in critically ill patients with severe traumatic brain injury and subarachnoid haemorrhage**
Mr Menino Osbert Cotta

**Survivors of ICU with diabetes type 2 and the effect of shared care follow up clinics: The SWEET-AS feasibility study**
Dr Yasmine Ali Abdelhamid

**Targeted temperature management for traumatic brain injury: a feasibility study of strict normothermia**
Dr Manoj Saxena
*Knapp Family Grant*

**Randomised controlled feasibility trial of conservative vs usual fluid management in critically ill adults**
A/Prof. David Gattas

Trainee Project Grants were awarded to:
Dr Damian Bradley
Dr Kristin Hayres
SAFETY & QUALITY COMMITTEE

The ANZICS Safety and Quality Committee has recently enacted its Terms of Reference. It is with pleasure to introduce your Regional S&Q Representatives. John Gowardman (QLD), Deepak Bhonagiri (NSW) Arthas Flabouris (SA), Jonathan Barrett (VIC), Simon Towler (WA), Craig Carr (NZ), Christopher James (Paediatrics), Mary Pinder (CICM).

ANZICS and CICM are working together to develop a combined position statement on The Role of Intensive Care within Rapid Response Systems (RRS) has progressed to the stage of formation of writing groups to answer pre-defined questions, and commencement of work within the writing groups. Each writing group is made up of experts in the field for their particular question and led by a member of the Steering Committee which is made up of 5 ANZICS members and 5 CICM members. Each writing group has held a teleconference prior to commencing work with the Steering Committee leader providing guidance regarding methodology. 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 is continuing to have 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.

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. This is the largest international conference supporting rapid response systems across the globe. The Organising Committee for this years conference have developed a thought provoking and challenging scientific program delivered by inspirational global and local speakers. We have expanded the scope of the conference beyond Rapid Response Systems to the broader concept of deteriorating patients. In addition, the program will explore innovative ways to detect and respond to all deteriorating patients including the emergency department, mental health, obstetric, paediatric and general wards. There will be a strong emphasis on technology, team training and improving processes of care.

The Conference will be held at the world class Melbourne Convention and Exhibition Centre which is ideally situated close the heart of Melbourne on the banks of the iconic Yarra River. Melbourne is Australia’s leader in arts, sports, fashion and has some of the finest restaurants in the country.

Further information is available from the Conference website www.isrrs2016.com.au

Key Dates

- Abstract Opens 30 October 2015
- Registration Opens 30 October 2015
- Abstract Closes 15 February 2016
- Notification of Abstracts 29 February 2016
- Early Bird Registration Deadlines 4 March 2016
- iSRRS 2016 2-3 May 2016

Angus Carter
Immediate Past Chair, NSW

Committee membership

Immediate Past Chair, NSW
Angus Carter

SA
Arthas Flabouris

NSW
Deepak Bhonagiri

CICM
Mary Pinder

ACCCN
Bernadette Grealy

WA
Simon Towler

NZ
Alastair (Craig) Carr

QLD
John Gowardman

VIC
Jonathan Barrett

Paediatric
Christopher James

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Regional Meetings

There has recently been agreement from the NSW Committee that Regional meetings will be on ‘business of medicine’ events and visitors of note. New South Wales have been fortunate in obtaining funding from Pfizer for three to four Regional meetings a year. The meeting will be nonmedical in nature, although, Pfizer will be promoting their products at these meetings but will not be presenting. I am mindful that there may be objections to payment from Pfizer for the event, with the option of self-funding a meal available.

Mark Nichols, Chair, New South Wales

NSW Government and NSW Health

For NSW there are currently no major issues in the region. A strong members base increases the strength of ANZICS as an advocate for intensive care. We also need to advocate for our more junior Trainee members. We will be in contact with local hospital ANZICS members to help facilitate membership. Please do not hesitate to contact myself or any Committee Member if you have any questions, comments or concerns. All the best in the New Year and have a safe and happy break.

Mark Nichols, Chair, New South Wales

Committee Membership:

Chair: Mark Nicholls
Deputy Chair: Vacant
Secretary: Vacant
S&Q: Deepak Bhonagiri
Price: Mark Nicholls
Paediatrics: Andrew Numa
Education: Michael O’Leary, Elizabeth Fugaccia, Dhaval Ghelani, Charudatt Shirwadkar
CTG: Manoj Saxena, David Gattas

NEW ZEALAND

By the time you read this article, we should all be recovered from the 2015 Annual Scientific Meeting, held this year at SkyCity in Auckland. At the time of writing, I know that there are already well over 1,000 registered delegates, so it promises to be a great success. Thank you to all those who contributed to the success of this ASM, especially to Alex Kazemi and Nic Randall the Medical Convenors, Debbie Massey and Alison Parrett the Nursing Convenors and Fiona Miles and Nicola Gini the Paediatric Convenors. Many thanks also to all of the speakers and presenters, the industry delegates and exhibitors and to all of you who took the time to attend this meeting. I hope that you will all have some great memories to take away of the networking opportunities and social functions as well as the scientific content from this ASM.

Next year we revert to holding the local New Zealand Annual Scientific Meeting; the venue is the Novotel in Rotorua, the dates are Wednesday 30th March – Friday 1st April 2016. Jonathan Albrett from New Plymouth leads the team as Medical Convenor, with assistance from the ICUs of the Taranaki, Rotorua and Bay of Plenty Hospitals. This will be the first combined NZ ANZICS meeting with the newly-formed New Zealand College of Critical Care Nurses. The theme of the meeting is “Should I stay or should I go?” The NZ branch of the Intensive Care Network was set up earlier this year, aided by a grant from the NZ ANZICS funds. The next meeting is likely to be early in the New Year, so look out for an announcement. Podcasts of previous events are now available on the ICN website.

The next Wellington Intensive Care Examination Course, supported by NZ ANZICS, is planned for Tuesday 28th June – Friday 1st July 2016. Details will soon be available on the Wellington ICU website. This Course attracts Second Part Examination candidates from around New Zealand as well as Australia and Hong Kong; so please let your Trainees know of this excellent Course early to avoid any disappointment.

Finally, congratulations to all those NZ ANZICS members who have contributed to several high profile ANZICS CTG endorsed studies published this year: ‘Acetaminophen for Fever in Critically Ill Patients with Suspected Infection’, (HEAT) in the New England Journal of Medicine; ‘Effect of a Buffered Crystalloid Solution vs Saline on Acute Kidney Injury Among Patients in the Intensive Care Unit’ (SPLIT) in the Journal of the American Medical Association; and ‘Erythropoietin in traumatic brain injury (EPO-TBI)’ in The Lancet.

Paul Young from Wellington Hospital was first author on the first two of these papers, attracting well-deserved recognition for his achievements in running these trials. Other authors of these papers who are New Zealand intensive care clinicians include Colin McArthur, Seton Henderson, Shay McGuinness, Ross Freebairn, Alex Psrides, Diane Mackle and Jan Mehrtens. It is a great inspiration to potential researchers that not only can the ANZICS CTG produce world-leading critical care research but that some of this work is now being led by New Zealand Intensive Care Physicians and Research Nurses.

Ben Barry, Chair, New Zealand

Committee Membership:

Chair: Ben Barry
Vice Chair: David Knight
Secretary: vacant
Treasurer: Nic Randall
Abstract Review: Paul Young, David Knight, Ben Barry
CTG: Paul Young
Paediatrics: vacant
Price: Ywain Lawrey
DODC: James Judson, Stephen Streat
Safety & Quality: Craig Carr
Education: vacant
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At the outset, I would like to congratulate the following Queensland ANZICS members for their success in a recent election.

1.) A/Prof Jeremy Cohen – Queensland Representative to ANZICS CTG
2.) Dr John Gowardman - Queensland Representative on the ANZICS Safety and Quality Committee.

The major issue that confronted QLD ANZICS in last 3 months or so, was the negotiation of the new EB (enterprise bargaining) agreement (MOCA 4). Queensland Health Minister, Cameron Dick and Premier, Annastacia Palaszczuk announced on the 16th August, 2015 that the controversial Doctors’ health contracts are to be abolished from Queensland Health, replaced by a new three year enterprise bargaining agreement. This was a big win for all Queensland Health Doctors.

Major concern was expressed to us by our members, about the clause of “the extended hours” in the initial MOCA 4 draft proposed by Queensland Government. Queensland ANZICS, including both Chair and Deputy Chair, lobbied strongly with the ASMOFQ and Togetheer Union to make appropriate changes to this draft. ANZICS Queensland organised a meeting with ASMOFQ President and his team on the 10th July to express our concern that the draft, as it stood then, would potentially result in Hospital Administrators using ICU Specialists as hospitalists looking after ward patients after hours and weekends. The ANZICS gave opportunity to its members to have a direct conversation with ASMOFQ led by President, Dr Steve Morrison via teleconference.

Queensland ANZICS kept in touch with ASMOFQ with each draft to ensure that the “extended hours” clause could only be implemented with a written agreement from an individual Senior Medical Officer. We strongly believe that the final agreement signed by ASMOFQ and Together Union with the QLD health has protected our members from being forced into shift work or “extended hours” work for at least another 3 years. Certification of the agreement is dependent upon a majority of SMO and RMO Doctors voting in favour in the ballot.

We will inform our members as and when this agreement is legislated into a law. I request all Queensland ANZICS members to contact us (Dr Rajeev Hegde or Dr Siva Senthuran) if they have any questions about the new agreement or wish to discuss any local issues related to this agreement.

Rajeeve Hegde,
Chair, Queensland
South Australian Clinicians have again had excellent representation at the ANZICS ASM. Dr Palash Kar won the Matt Spence Medal, making that the 5th year in a row that a Trainee from either the RAH or TQEH has won the Medal. Palash is part of the thoroughbred RAH research stable that is producing some very high quality young researchers. Credit must go to A/Prof Adam Deane, Prof Marianne Chapman and A/Prof Sandy Peake for mentoring the research interests across both hospitals.

Thank you to Dr Krish Sundararajan for his time as S&Q Representative, A/Prof Arthas Flabouris was successfully appointed as his replacement in this position. Arthas is a tireless contributor, who along with Dr Matt Maiden is assisting in the joint CICM/ANZICS rapid response team document. The other contested position was the SA CTG Representative, A/Prof Adam Deane was successful in retaining his position.

Within SA, Transforming Health is impacting all SA hospitals. The aim to streamline and improve efficiencies within the system is an important goal. Like many paper-based efficiency drives, care must be taken that unintended consequences do not adversely impact those patient groups who do not fit neatly into administrator categories.

I will be vacating the SA Chair after over 4 years in the position. ANZICS SA would benefit from representation by all hospitals within SA and I look forward to working closely with the new Chair once appointed. Thank you to all the ANZICS central staff and the Board for their support during my tenure. Also a big thank you to all SA Clinicians who have supported local ANZICS activities during this time.

Stewart Moodie
Chair, South Australia

Committee Membership:

Chair: Stewart Moodie
Vice-Chair: Ken Lee
Abstract Review: Adam Deane, Matthew Maiden
S&Q: Arthas Flabouris
CTG: Adam Deane, Sandy Peake
Education: Mary White
Australian Resuscitation Council: Stuart Baker
PricE: Nick Edwards
Paediatric: Ranjan Joshi

Tasmania is moving into the implementation phase of a long term, state-wide health reform process. It is interesting to now reflect on both the influence of the Tasmanian Intensive Care community and ANZICS on this complex process, and its impact on our ICU’s. Changes to clinical services in other disciplines, such as surgery in the North West and a state-wide trauma service, will certainly impact Intensive Care through changing demand patterns right across the state. We are fortunate to have a relatively small but very cohesive cross-disciplinary workforce in Intensive Care here in Tasmania. This is reflected in a highly functional ICU Clinical Advisory Group, which will inform government on the impact of changes on each ICU, will help determine how we will adapt as a result and to outline the minimum standards for safe ICU practice.

Many challenges remain, but there is room for cautious optimism as we try to adjust services to better match demand. The biggest tasks will be adequate resourcing of future nursing and medical workforces for our two major ICU’s, as demand inevitably continues to rise, as well as maintaining access to perioperative ICU/HDU beds. Data from ANZICS APD and CCR Survey has, and will continue to be extremely useful in informing much of this work. The ICU CAG will hopefully take on a ‘Data Review Committee’ role as this all evolves.

After returning from an excellent ANZICS ASM in Auckland last week, I received several requests for information on the ‘Goals of Care’ system which was rolled out across Tasmania’s major hospitals over the past few years. There was significant input from Intensive Care staff at Royal Hobart in initial planning of this project. This system provides a clear, well-structured framework and consistent language around decisions with respect to resuscitation and treatment goals for inpatients, and was written up in the MJA in 2014. There is currently much work going on in this space, in both New Zealand and Australia, through ANZICS, ASCSQ amongst other organisations, and more recently on SBS Insight program, accessible online. Great to see interest in a locally developed system, which is now fully embedded into hospital culture and language across the state. We all know how these issues affect demand for our services if not dealt with appropriately.

David Rigg
Chair, Tasmania

Committee Membership:

Chair/PricE: David Rigg
CTG: David Cooper
Abstract Review/Education: Andrew Turner
S&Q: Vacant
DODC: Vacant
**THE AUSTRALIAN & NEW ZEALAND INTENSIVE CARE SOCIETY**

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“The measure of intelligence is the ability to change” - Albert Einstein

It’s difficult not to lapse into clichés when describing the rapid rate of change occurring within intensive care. Whilst coping with change has always been a necessary part of any successful human endeavour, the current rate of change is unprecedented. Simply scanning down the program of the recent Auckland ASM provides a remarkable insight: the dissolution of old and the emergence of new therapeutic paradigms, complex training challenges, workforce planning, resourcing for increasingly expensive treatments in the context of major financial constraints, addressing gender imbalance within the specialty, the opportunities and pitfalls of social media, and challenges associated with difficult end-of-life care decision making are just some of the fascinating topics discussed.

The importance and potential impact of these issues is obvious, however it will be our ability to adapt that will largely determine future directions for intensive care. Clinicians have not always necessarily demonstrated much agility when it comes to negotiating a way forward through periods of rapid innovation and change. Perhaps intensive care is different? As a young and technically inclined specialty, might we be well placed to manage these complexities? Talking with Victorian colleagues, I am struck by the energy, enthusiasm and commitment to embracing the opportunities opening up for intensive care.

Coupled with visionary ideas for where we are headed, there continues a clear commitment to ensuring that we bring the very best of past and current experience along to inform future decisions and strategy. The Society’s ability to support Trainees and new Intensivists as they commence their professional journey will prove essential to ensuring that critical care practice maintains the globally recognised standards of excellence that have been established in our region.

Victoria has experienced a highly successful year in 2015, with the continued maturation of broad-based educational programs, national leadership in organ donation, remarkable research outcomes, the expansion of intensive care bed numbers and the transition of a significant number of high calibre Trainees to Consultant positions. A few of these achievements are worth specific mention. Rinaldo Bellomo has continued his remarkable academic leadership that has led to the publication of three major scientific papers in NEJM, JAMA and the Lancet within the space of a mere twenty-four hours. John Santamarie was added to the ANZICS Honour Roll for his outstanding contribution across a broad range of critical care endeavours over many decades. Helen Opdam was also added to the ANZICS Honour Roll for over a decade of demonstrated leadership within organ donation during which she has ensured Intensivists remain integral to donation practice. Cameron Knott was awarded the 2015 Ramesh Nagappan award for his contributions to intensive care education. Congratulations to these Victorian ANZICS members who exemplify the commitment and achievement within our ranks.

I would like to take this opportunity to thank everyone within the ANZICS team for their unstinting support throughout 2015. Justin Williams has been a wonderful advocate for the Society during his time with us and on behalf of all Victorian members I extend our very best wishes with his future endeavours. The ANZICS staff are one of our greatest assets and I am grateful for their professionalism and engagement with all aspects of ANZICS activities during the year. I’m sure that the team will work hard to ensure that Tony Tenaglia is welcomed and supported as he settles into his role as the newly appointed ANZICS general manager and CEO. Thanks to Ben Gelbart and David Ku, who are excellent contributors to promoting the work of ANZICS in Victoria and will continue to advance important developments in 2016. Finally, thanks to all Victorian ANZICS members for your enthusiastic engagement with the Society in 2015 - I look forward to a remarkable coming year in 2016.

Stephen Warrillow
Chair, Victoria

Committee Membership

Chair
Stephen Warrillow

Vice Chair
Ben Gelbart

Secretary
David Ku

DODC/EOLCWG
William Silvester

S&Q
Helen Opdam

Jonathan Barrett

Abstract Review
Ravi Tiruvoipati

Education
Sam Radford

CTG
Craig French, Andrew Udy

CORE
David Pilcher
The fairly abrupt end of the mining boom has caused the Western Australian government to receive a rude shock with respect to the balance of revenue and expenditure, resulting in a strong push to reduce hospital’s budget deficits. Additionally, Western Australian hospital nursing and medical staff have enjoyed, in recent years some of the better pay of the Australian jurisdictions- at least in terms of the published rates. This has been one factor resulting in most WA hospitals exceeding the national efficient price for many services i.e. we appear less cost-efficient than the Eastern states.

This has caused the Health Department to embark on a cost-cutting drive, including a push to reduce, by as yet an unspecified amount, full time equivalent (FTE) employment. This may well include senior medical staff, including those working in Intensive Care- the industrial landscape in WA is a little different from other jurisdictions in that most senior staff are employed on five year contracts rather than being permanent and there is specifically no automatic right of renewal at the expiration of contracts-although very few have been made redundant by this mechanism in the past.

There has also been a concerted push to reduce junior medical staff employment expense by reduction of number of rostered staff and reduction in overtime costs. There has also been a shortage of suitable Registrar-grade and SR-grade doctors to work in ICUs, especially in the metropolitan ICUs, but also in the tertiary units. Some full ANZICS members are having to staff ICU shifts without a Registrar on duty in the ICU.

With this background the Directors of the ICUs in the South Metropolitan Health Service have formed a Committee to advise their health service on operational and strategic imperatives. Top of the list will be staffing, inter-hospital transfers and research- a now neglected area of endeavour in the quest to cut any ‘non-clinical’ costs. Perhaps ANZICS (WA) could play a role in this space and play a metropolitan-wide role.

On a more positive note, in the last quarter we have had an excellent evening educational meeting, jointly hosted by Intensive Care Network (ICN) and ANZICS (WA) and sponsored by Nikkiso, featuring a talk on right heart failure and pulmonary hypertension by A/Prof David Playford and a presentation on cardiac transplantation by Mr Robert Larbalestier, and have another meeting looming, organised by ICN.

During the last quarter Ed Litton has been re-elected unopposed as the WA Representative on CTG Executive and Simon Towler has replaced Krishna Ponasanapalli as the WA Representative on the ANZICS Safety & Quality Committee. We do seek a WA member to participate on the CORE Jurisdictional Advisory Committee.

Well, the Festive Season is fast approaching, so I would like to wish all members a Merry Christmas and a Happy New Year, and trust we all get a little time off over the holidays to relax before what promises to be professionally an exciting, challenging and potentially somewhat uncertain 2016.

Ian Jenkins, Chair
Western Australia