

**AUSTRALIAN NEW ZEALAND INTENSIVE
CARE SOCIETY**



PRACTICE AND ECONOMICS COMMITTEE

**ADJUSTMENT TO SUB-GROUP 10
INTENSIVE CARE MANAGEMENT ITEMS**

SUBMISSION TO THE

**DEPARTMENT OF HEALTH AND AGEING
CANBERRA**

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Executive Summary

Since the introduction of Intensive Care management items in the Medicare Benefits Schedule, there has been a significant expansion in the scope of Intensive Care Unit activity and in Intensive Care Specialists' clinical practice. These changes in scope are the result of a number of different but interrelated factors: (i) the changing demographics of hospital admissions, with an increasing elderly population with more complex disease being offered increasingly complex treatments, (ii) the increased acuity of hospital admissions, with the less sick now generally managed as day-stay or out-patients, and (iii) a change in the way hospitals identify and manage patients with, or at risk of, developing serious illness. In the past principally the "parent team", consisting of single specialty doctors possibly with a generalist interest, would manage this latter group of patients. Today it is recognised that specialists with training in the identification and management of critical illness better serve these patients. Hospitals have thus now become reliant on Intensive Care specialists being available to provide highly specialised expertise throughout the hospital 24 hours a day all year round.

The Australian & New Zealand Intensive Care Society (ANZICS) believes that the current MBS Intensive Care items no longer reflect contemporary Intensive Care practice and that a major revision is required in order to more closely align benefits with current and future trends in medical practice such that the Australian population can be assured that high quality Intensive Care services will be maintained and developed in both the Public and Private sectors. Furthermore, despite an expansion in Intensive Care units in both Public and Private sectors, and increased numbers of graduates from the Joint Faculty of Intensive Care Medicine's (JFICM) training programme, there remains a shortage of Intensive Care specialists in Australia. This shortage is most marked in the Public sector and in rural and regional areas, and with the likely continuing need for expansion in Intensive Care services, it will be exacerbated rather than reduced in the future. Intensive Care medicine remains



an unpopular specialty choice amongst Australian medical graduates, with many of our specialist graduates in recent years having obtained their primary medical qualification overseas. We believe that this situation is not sustainable, and that the unpopularity of the specialty to local trainees is at least in part related to excessive workload experience of Intensive Care specialists and lack of parity in remuneration when compared with other specialist doctors.

We believe that this submission represents a modest but significant step designed to create a long-term competitive advantage for Intensive Care as a specialty, to produce a self-sufficient Australian medical workforce in Intensive Care and to encourage rural and regional based medical practice. In addition, the proposed changes will complement the Government initiative to improve Australia's poor organ donation rate, which requires additional medical specialists that are most likely to come from the Intensive Care specialist pool.

The submission is based on the following principles:

1. Presenting a modern updated definition of an Intensive Care Unit (ICU).
2. Restructuring the current management items into a 3-tier system to better reflect the widened spectrum of disease complexity. This is achieved through the introduction of "higher complexity" and "lower complexity" management items in addition to the standard items, 13870 and 13873.
3. Introducing a Public Holiday and Weekend loading of 35% for the management items related to Intensive Care medicine.
4. Introducing items for a Case or Family Conference and for Prolonged out of ICU Consultation.



The financial projection for the proposed changes is a 14.54% overall increase in the Intensive Care sub-group 10, which equates to a total increase of \$33,224 per 100,000 population. We believe that this represents a small investment to help secure the future of intensive care medicine and ensure the continued provision of modern health care for all Australians.



1. Background

1.1 The current role of Intensive Care in Australian hospitals

Intensive Care has become a crucial and pivotal service in acute care hospitals in Australia. Initially conceived as short-term life saving vehicles for the acutely ill or injured, ICUs have now expanded to care for seriously ill people with chronic underlying diseases. Along with this, the Intensive Care specialist, or Intensivist, has often also changed from a “part-timer” with a parent specialty in either anaesthesia or general medicine to full time specialists in a relatively new specialty, which in 2010 will finally have its own independent College (The College of Intensive Care Medicine (CICM), Australia & New Zealand)ⁱ. Besides caring for critically ill patients within the confines of the Intensive Care Unit, Intensivists have become the “safety valve” of hospitals, providing a wide range of acute care services throughout the hospital, such as Medical Emergency Teams (MET)ⁱⁱ, resuscitation services and emergency ward consultations. These services are required 24 hours a day and seven days a week. Provision of safe and high quality care to patients in general hospital wards is now highly dependent upon a functional and effective ICU supported by highly trained Intensive Care specialistsⁱⁱⁱ.

The expansion in the role of the ICU and of Intensivists within the hospital in general has been associated with a significant increase in workload for these specialists. This is principally related to the changing demographics of the Australian population and of hospital and ICU admissions that has already occurred and is predicted to continue to occur over coming years. The recently released Australian Hospital Statistics 2007-08^{iv} showed that Public hospital separations increased between 2003-04 and 2007-08 by 12.9% but this increase was more pronounced in elderly patients, with separations increasing by 20.6% for patients aged 75-84 years and 28.8% for patients aged over 85 years. This increase in hospitalised elderly patients does seem to translate into an increase in elderly patients admitted to ICUs. The most recent published Australian data found an increase in



admission of patients to ICUs aged over 80 years of 5.6% per year between 2000 and 2005^v. These patients were found to have more co-morbid illness (i.e. significant illnesses not directly related to the condition necessitating ICU admission) and greater illness severity than younger patients. The trend to more elderly patients being admitted to ICUs is likely to increase, with Australian population projections estimating that the proportion of the population aged over 65 years will increase from 13% in 2006 to 24% by 2036. This figure, although alarming, does not give a true representation of the issue, however, as it is in the elderly group that the advances in life expectancy will come: the 65 year old in 2036 will be much more likely to survive to 100 than their counterpart today^{vi}, and they will expect a level of health care to deliver them that outcome. Evidence from clinical studies indicate that even patients of advanced age return to their prior level of functioning if they survive an Intensive Care admission, and indeed in keeping with published series from elsewhere, approximately 80% of the cohort described in the Australian study survived to hospital discharge. Whilst elderly patients are recognised to present with more complex disease and greater numbers of co-morbid illnesses it is also apparent that today younger patients are also more likely to have significant co-morbid illnesses than in the past. This is related to our increased ability to achieve prolonged survival in conditions that in the past were associated with early death, such as chronic heart failure, chronic obstructive pulmonary disease, renal failure and many cancers. Objective data demonstrating an increase in illness acuity and in co-morbidities amongst hospitalised patients is difficult to collect, but it is of interest that the Australian Hospital Statistics 2007-08 reports that the principal diagnosis with the greatest increase in separations between 2003-04 and 2007-08 was *Care involving dialysis*⁴. In 2009, patients with acute renal failure in Australia will be most commonly managed by an Intensivist, in an ICU, as will patients with chronic renal failure that develop any significant intercurrent illness^{vii,viii}.

The Australian Hospital Statistics 2007-08 also indicated an increase of 18%, in Private hospital separations during the period in comparison with 2003-04. However surgical care



accounted for 41% of admissions compared with only 26% in Public hospitals⁴. Overall, the Private hospital sector was responsible for 62% of the elective surgical workload in Australia. Maintaining an efficient and safe elective surgical programme mandates the provision of high quality Intensive Care services. In Private hospitals 64% of ICU admissions are deemed "elective" compared to 54% in Public hospitals, which reflects the surgical preponderance. Whilst Intensive Care severity of illness scoring systems such as APACHE demonstrate reduced severity for Private hospital ICU admissions compared with Public this is difficult to interpret given the effects of admission from Operating Theatre and lead time bias. However patient admission rates to ICU are similar to those in Public hospitals, suggesting that the acuity of patient illness is similar^{ix}. As with Public hospital separations, in 2007-08 the increase in Private hospital separations was most marked for patients aged 55-64 years (31.5%) and the 85 and over group (48.1%). Private hospital patient days increased by 25.6% for patients aged 85 and over⁴.

1.2 Changing models of Intensive Care service delivery

The increasing caseload and acuity of patients presenting to hospital has created a significant increase in demand for the expertise of an Intensive Care specialist. Intensive Care bed numbers did not increase significantly between 2002-03 to 2005-06 in either the Public or Private sectors^{ix,x}. However, hospitals have accommodated the increase in case load demand by amalgamating sub-specialty ICUs into larger ICUs staffed and run by Intensivists. Within an ICU, therefore, casemix has widened to include patients with high complexity disease and multi-organ failure as well as patients with lower complexity (such as postoperative care of high risk patients) that still require intensive care management. In addition, a patient's stay in an Intensive Care commonly starts with multiple organ dysfunction (such as septic shock or severe pancreatitis) that may require complex organ system supports, and which gradually recovers over a few days or weeks. The final stage of



recovery is when organ dysfunction has largely resolved; such a patient might be considered of low complexity at this stage, although they frequently still require close monitoring and clinical expertise to prevent relapse. The current structure of the ICU benefits in the Schedule makes no consideration for the level of complexity of patients managed in an ICU, and consequently a tiered system of fees might better capture the clinical reality of workload associated with higher and lower complexity patients that are admitted to ICUs.

Outside of the ICU, coping with increased complexity of illness is a more difficult issue for hospitals and practitioners than dealing with increased demand. The spectrum of patients' complexity managed in acute hospital beds has increased as simpler cases are managed on a day-only or out-patient basis^{xi}. Changing patterns of medical and surgical specialist training and practice leave many specialists poorly prepared to manage the critically ill, acutely deteriorating patient on the ward, resulting in the development of the "Medical Emergency Team" (MET) concept^{xii}. This concept involves the expansion of the traditional "cardiac arrest team" with a more highly skilled team of individuals, run from the ICU, that can be summoned by any member of hospital staff to attend urgently to a patient in trouble on the general ward. A number of studies have now demonstrated that this intervention can reduce morbidity and mortality in ward patients^{xiii,xiv}. In 2005-06 57% of Public hospitals and 53% of Private hospitals were identified as having a MET^{ix}. MET activities now constitute a significant additional workload for Intensivists, with a median of just over one MET call per day^{ix}. Few MET-call patients require ICU admission, however, meaning that the Intensivist may spend considerable time on the general wards assessing and managing patients and counselling families and relatives^{xv}.

1.3 Intensive Care, quality and hospital outcomes

Intensive Care Medicine is a relatively young specialty worldwide, but in no country is the specialty better developed or more sophisticated, in training, accreditation or in practice,



than in Australia and New Zealand. Repeated international comparisons have demonstrated clinical outcomes in Australia and New Zealand that are as good as or indeed better than published outcomes elsewhere^{xvi}. This has occurred on the background of compliance with stringent standards, clinical audit and quality assurance. In Australia and New Zealand Intensive Care specialists have to some extent become the safeguards of the health care system - attending, treating and managing the acutely ill or deteriorating patient anywhere within the hospital at short notice around the clock. This occurs in both Public and Private hospitals, although is perhaps more crucial in Private hospitals where there is a paucity of highly trained junior medical staff present on the floor. The requirement for such attendances frequently occurs after hours with the presumption that there will always be an Intensive Care specialist on call and immediately available. Despite this reality, these attendances remain poorly remunerated in comparison with after-hours attendances of anaesthetists or surgeons.

1.4 The Intensive Care workforce in Australia: Present and future

The likely requirement for Intensive Care specialists in Australia was investigated in 1999 by the Australian Medical Workforce Advisory Committee (AMWAC)^{xvii}. This body forecasted a workforce requirement of 464 - 500 by 2008. It is not possible to precisely define the number of Intensive Care specialists currently practising in Australia, however there are currently (March 2009) 423 full members of the professional society, ANZICS. In terms of Full Time Equivalents (FTEs), there were 345.72 FTEs employed and 40.9 FTE vacancies in Public hospitals and 123.3 FTEs employed with 1 FTE vacant in Private hospitals in 2005-06⁸. However many of these FTEs may apply to the same individuals as it is not uncommon, for economic reasons, for Intensivists to cover "full-time" sessions in more than one institution. It would appear, therefore, that the Intensive Care workforce has not met the predicted requirement from the 1999 report, and moreover it is likely that this requirement



was conservative given that the expansion in the role of the Intensive Care specialist, although mentioned within the report, was not factored into the calculations used by the authors. In Australia and New Zealand, training of Intensive Care specialists is coordinated by the statutory body responsible for accreditation of Intensive Care specialists – The Joint Faculty of Intensive Care Medicine (www.anzca.edu.au/jficom). JFICM will become the College of Intensive Care Medicine (CICM) from January 2010. Despite a well-structured and internationally renowned training and certification program, Intensive Care remains an unattractive specialty option for local trainees. As at 25 March 2009 JFICM had 614 registered trainees. These trainees had obtained their primary medical degree in the following countries: Australia 230, India 200, UK 102, Ireland 27, Germany 14, Hong Kong 13, South Africa 11, Philippines 9 and 8 from Sri Lanka. That is, only 37.5% trainees are Australian graduates. This figure almost certainly under-estimates the unpopularity of ICU training amongst local graduates, because many Australian graduated trainees are dual trainees in another training scheme who sign up with JFICM in order to ensure that non-ICU posts will be accredited against the training program should they subsequently decide to pursue ICU training, as retrospective accreditation of training is not permitted. However, most of these trainees do not subsequently pursue a career in Intensive Care Medicine. Indeed, if those trainees graduating from the programme in 2008 are considered, nearly 80% had obtained their primary medical degree outside Australia. The 2020 Summit held in Canberra in 2008 called for a self-sufficient medical workforce in Australia by 2020^{xviii}. Whilst this is highly desirable and most critical in acute care specialities such as Intensive Care, the chance of achieving this goal is poor given current medical workforce projections and the effect of market forces. The lack of local graduates in the Intensive Care trainee pool is a major hurdle to achieving a sustainable workforce in the future. Unless this problem can be addressed as a matter of some urgency it is likely that the specialty of Intensive Care Medicine will suffer in disproportionate severity given projections of a medical workforce shortage in Australia over the next 20 years. Intensive Care is a speciality that is frequently



reliant on trainees changing their career choice after admission to the training programme of another College such as the Australian and New Zealand College of Anaesthetists, Australian College of Emergency Medicine or the Royal Australasian College of Physicians. This places the specialty of Intensive Care Medicine in direct competition with specialities that offer life style advantages and better remuneration. For example, a recent survey conducted by Access Economics for the Australian & New Zealand College of Anaesthetists (ANZCA) predicted a demand-supply gap for anaesthetists of 36% in 2028 assuming current growth rate continues^{xix}. The same survey found that there was no shortage of anaesthetists in 2008. As the bulk of Intensive Care trainees come from Anaesthesia and Emergency Medicine, these projections carry a serious threat to the medium and long-term viability and sustainability of the specialty of Intensive Care. The projected gap will be larger and the impact significantly worse in rural and regional Australia. It is imperative that a multi-dimensional approach is taken to address these issues through improvement in training programs, workload and lifestyle balance, effective models of care and parity and equity with other craft groups.

1.5 Impediments to specialist recruitment and retention in Intensive Care

1.5.1 Intensivists' workload:

The ANZICS PRiCE Committee has identified excessive workload, family & social life *versus* work imbalance, and disparity in remuneration when compared with peers from other specialties as major concerns for Intensive Care specialists in Australia. A recent survey found that in a 12-week cycle on average Intensive Care specialists are on duty for 5 weeks including weekends^{xx}. It also showed that the Intensive Care specialist shortage is masked by the high numbers of individuals working in a locum capacity additional to their primary appointment in order to catch up with economic demands. There is no data to suggest that such practice is common amongst other craft groups. These findings were not surprising given that there are less than 400 FTE ICU specialists in Australia providing services in 192



ICUs^x, which equates to close to a 1 night in 2 on-call roster for a full-time Intensive Care specialist. Furthermore the onerous on-call roster of the typical Intensivist is further aggravated by the frequency of late-night call-out and the acuity and urgency of the clinical problems encountered. Increasing reimbursement for ICU services is likely to be associated with improved ability to recruit specialist staff in both the Public and Private hospital sectors, although clearly only in the Private sector is improving rostering requirements directly related to MBS reimbursement, as new staff can only be introduced onto a roster if there is an increase in potential billings that would make the new post commercially viable.

1.5.2 Trainees' perception of Intensive Care:

In a survey conducted by the NSW Regional Committee of the JFICM in 2004, a worrying trend amongst trainees was observed^{xxi}. Whilst the majority were very satisfied with the academic and teaching side of intensive care, most were very dissatisfied with the lack of family and social time and life / work imbalance. In addition, there was almost unanimous dissatisfaction with the poor remuneration in comparison with peers graduating from other training programs. One means of avoiding what will be a drastic workforce shortage within one craft group of a profession that will have systemic workforce shortages in the future, is to achieve some degree of parity and equity in incomes, especially when measured against inputs - physical, intellectual and emotional.

1.5.3 Stress, anxiety and burnout amongst Intensivists:

A recent survey of Intensive Care specialists, published in a peer-reviewed journal²⁰, demonstrated that despite high rate of job satisfaction, 42% of specialists surveyed demonstrated signs of emotional exhaustion with the majority suffering psychological stress, discomfort and feelings of under achievement. We believe that these findings represent the collective effect of all the above factors combined.



1.6 Summary

Intensive Care now has a pivotal role in the safe and efficient running of acute care hospitals in both the Public and Private sectors. Changes in demographics of the Australian hospital population, combined with changes in the way hospitals manage patients with serious illness, have led to a significant increase in the work demands of Intensive Care specialists. Despite a world-class training programme and reputation, Intensive Care Medicine remains an unpopular career choice for Australian medical graduates. Excessive workload, onerous rostering and poor remuneration when compared with peers are cited by specialists and trainees as areas of major concern relating to career choice. ANZICS believes that there is urgent need for action to improve the position of Intensive Care specialists in comparison to other craft groups such that endemic problems with recruitment and retention of specialist staff do not become embedded in the Australian medical system. If these issues are not addressed, our ability to ensure that high quality Intensive Care services are available to all Australians is likely to be compromised.



2. Rationale for the Proposed Changes to the Intensive Care MBS

2.1 Updated definition of an Intensive Care Unit (ICU)

ANZICS is keen to ensure that the rebate for Intensive Care management items is only available to patients receiving treatment in a hospital area that is appropriately managed, staffed and equipped such that the patient has available to them the full range of treatment that would be considered Intensive Care. Hence we have updated the definition of an ICU to reflect contemporary practice. In formulating this new definition we have been cognisant of the need not to inadvertently disenfranchise any specialist currently providing appropriate Intensive Care services, as we recognise that especially in rural and regional areas it may not yet be possible to ensure that specialists with JFICM-approved qualifications are available to manage and staff ICUs.

2.2 New structure to ICU management items

In order to better reflect the expanded acuity of patients admitted to ICUs we propose a new three-tiered structure additional to the ICU management items 13870 and 13873, with the introduction of new "High Complexity" and "Low Complexity" items. In order to define complexity we have adapted a validated organ failure scoring system, the SOFA score^{xxii}. It is clear that any system introduced to judge complexity would need to be simple, able to be performed at the patient's bedside from readily available observations or data on a daily basis, and to be robust to inter-observer variation to permit simple and reliable audit. We believe that this system fulfils these criteria. Our intention in the design of the system is to effectively identify patients of "High Complexity"; for example a routine post cardiac surgery patient will fall into the middle bracket and not "High Complexity". We anticipate that the system will result in approximately 15% of current 13870/3 falling in the "High Complexity" bracket and approximately 20% falling in the "Low Complexity" bracket. We base these



estimates on a small audit of billing we have conducted across three metropolitan hospitals in Sydney.

With this new tiered system patients may move between tiers on a day-to-day basis during their Intensive Care stay. For example, a patient admitted to ICU following major trauma may be graded as “High Complexity” on their first day, and would be billed a “High Complexity” – First Day fee. The following day they may remain “High Complexity” and attract the “High Complexity” – Subsequent Day fee. The next day they may fall to “Low Complexity”, and be eligible for the “Low Complexity” – Subsequent Day fee. If the patient were now to suffer a pulmonary embolism, for example, they might move up to the standard, mid-tier Subsequent Day fee for the following day, or even back to “High Complexity” – Subsequent Day. Note, however, that First Day of Management can only be charged once, on the day of ICU admission, and will relate to the complexity on that day.

In setting the benefit for each item we have been especially cognisant of the need not to adversely impact on the income of any group of our constituency, specialists caring for patients in ICUs. There is undoubtedly variation in ICU case mix across the country and this is possibly most marked between rural and regional units and metropolitan units. It would be completely counter to one of the leading principles underlying this submission to put in place a structure that negatively impacts on the attractiveness of rural and regional Intensive Care practice. As rural and regional units care for patients with a lower complexity of illness than metropolitan units we have therefore set the benefit for the “Low Complexity” items at the current 13870/3 level and graded the standard and “High Complexity” items appropriately above this. We have thus calculated that no ICU specialist will be disadvantaged by the introduction of this new structure.

2.3 Public Holidays and weekend component

Intensive Care specialists not only care for and manage patients within their ICUs on a 24 hours a day, seven days a week basis, but similarly provide consultations, manage and treat



acutely and critically ill patients on hospital wards and in Emergency Departments around the clock. None of the current item numbers were drafted or priced with consideration for such a significant proportion of the work being in anti-social hours. Between 22-24% of all ICU attendances occur on a Saturday, Sunday or Public Holiday. This is to be expected given the emergent nature of much of the work. However, the case remains in the Private sector where a vast majority of work is Monday to Friday but still over one fifth of admissions present to the ICU on weekend or Public Holiday days. Currently no differential is applied to these situations where Intensive Care specialists are available after hours and on every weekend and public holiday maintaining patients' care, whilst availability of non-intensive care colleagues is at its numerical lowest.

In drafting this addition to the fee structure we have taken note of existing out of normal hours fees available to other specialists that apply only to emergency attendances. Given that the ICU management items apply to a whole day of management, we consider that it would be inappropriate to place a weighting on these simply because the patient presented to ICU outside normal working hours on weekdays where the majority of management is likely to occur during normal working hours. Hence the after hours loading will not apply to patients admitted on normal weekday nights. In terms of onerous hours and rostering it is prolonged attendance at weekends and on Public Holidays that have most impact on specialists work / life balance, and we believe that Intensive Care specialists alone are subject to an excessive exposure to attendance during these periods.

2.4 Family and Case Conferences:

The nature of intensive care management lends itself to a unique relationship with the immediate family of critically ill patients managed in by Intensive Care specialists. It is not uncommon for an Intensive Care specialist to be involved in 2 to 3 family and case conferences per day. Our recent survey in 2007 showed that the average time for such



conferences is 0.59 hours (40 min). The best example of such case conferences are those conducted in relation to withdrawal of therapy or in the process of obtaining consent for organ donation. It is a sobering thought that overall about 10% of ICU admissions end with the patients' death, and in over 70% of cases death follows an agreement between the medical teams and the patients family to withhold or withdraw life sustaining therapies^{xxiii}. Anecdotal evidence suggests that these conferences are increasing in their complexity and onerous nature. This may simply be because of the changing patient demographic, with each case more likely to be complex and to involve a number of different medical, nursing and allied health teams. It is also possible that other issues are involved, such as the changing social demographic of the Australian population and differing cultural and immigrant patterns. We believe that this important aspect of the Intensive Care specialist's workload needs specific recognition. The payment of a benefit for such activities may help promote the standardisation of a multi-disciplinary approach, common in the Public sector, into the Private sector. Furthermore, the recent recognition by the Federal Government of the role of Intensive Care in organ donation, along with the \$150 million initiative to boost organ donation in Australia, highlights the critical role of case and family conferences conducted by Intensive Care specialists in this process of care.

2.5 Prolonged out-of-ICU consultation:

As already outlined, the work of the Intensive Care specialist is no longer primarily confined within the ICU. Frequently Intensivists will be called upon by their specialist colleagues, now commonly trained mainly in the management of problems confined to a single organ or organ system, to consult on the management of complex patients on the ward. Often such consults may not result in the patient's subsequent admission to the ICU. This may have significant resource implications for the health system in general as it is clearly inappropriate for patients to be admitted to ICU who cannot benefit from admission – either because they are too well to do so, or because they are very likely to die with or without Intensive Care



admission. These consultations are often very complex, and may involve the organisation or collation and review of investigations, taking detailed history, exploring treatment options, discussion of care plans with patient and family, telephone conversations with other specialists, or discussion within a multi-disciplinary team. We consider that these consultations are not clearly distinguishable in nature from consultations by a Consultant Physician but rather more complex and take longer time. However, for Intensivists who are not Consultants Physicians, there is no item that reflects the service provided. Hence we propose two benefits to be payable in respect of these activities: (i) a simple consult, lasting up to 45 minutes, with a benefit at the same level as a consultation by a Consultant Physician (Item 110); and (ii) a prolonged consultation, lasting greater than 45 minutes, equivalent to level 5 emergency consultation (item 515).



3. Financial and social responsibility

3.1 No out of pocket expenses for patients treated in intensive care

Intensivists treat and care for the most critically unwell, the frailest and the most vulnerable in our health system. The unpredictable nature of an intensive care admission and clinical priorities often makes Informed Financial Consent impractical and unattainable. A stay in Intensive Care, let alone a prolonged one, is often not anticipated by patients. Even when they were employed prior to an acute severe illness, they often require up to several weeks or months of rehabilitation prior to returning to full-time employment. They often have other significant out-of-pocket expenses (pharmacy, radiology, pathology, hospital costs etc). The vast majority of Intensive Care specialists, despite inadequate Medicare rebates, continue to subsidise patients' care by charging no out-of-pocket expenses (gap) payments over and above the payments afforded by "no gap" schemes offered by the health funds.

When health funds established no-gap and known-gap products eight years ago Intensive Care specialists were further penalised, as health fund fee schedules were based on historical billing patterns and as such the schedules were established at or just above the CMBS for Intensive Care. When the gap benefits paid to procedural medical specialists, surgeons and anaesthetists are considered in comparison to those offered to Intensivists the lack of parity differential already inherent in the Schedule becomes even more marked.

3.2 ANZICS values and principles

ANZICS believes that the fee structure is not just a monetary vehicle, but rather a driver for best practice and should enhance and embrace quality based medicine. This submission is designed to reflect current practice and encourage models of contemporary intensive care practice.



ANZICS embrace the belief of fairness and equity amongst practitioners, particularly outside the tertiary centres. ANZICS has and will always continue to support rural and regional Intensive Care specialists. With this in mind, therefore, we have designed this submission such that any change to the fees structure will not disadvantage practitioners in smaller units to the benefit of busy tertiary practice. We believe that this principle must remain fundamental to any change in the Schedule. This current submission will provide modest benefits across the spectrum of intensive care practitioners.

We have modelled our submission along ANZICS longstanding values and principles of social and financial responsibility. With the global economic downturn in mind we believe that we have exercised financial constraint in our submission, in particular in limiting the weekend / Public Holiday loading to 35% in comparison to that of a comparative peer group currently at 50%. We have also proposed that Public Holiday and weekend loading only applies to the management items rather than all of subgroup 10.



4. Financial Projections

The growth for all Medicare benefits over the last 3 years is 9.43% (**Figure 1**) whilst that for Subgroup 10 for intensive care benefits over the last 2 years is around 9%.

The growth rate in benefits and services in individual Subgroup 10 intensive care item numbers is summarised in Table 1..

In building the financial model for the proposed changes, the following assumptions were made:

1. 9% projected growth in benefits for 2008/2009.
2. 76% of management items occur on week days (Monday to Friday).
3. 24% of management items occur on weekends and public holidays.
4. 35% loading for management items on weekends and public holidays.
5. Low complexity services is estimated to be 20% of current 13870 whilst high complexity services is estimated to be around 15% of current 13870.
6. The benefits for the low complexity item equal the current benefits for 13870. This is to not disadvantage units with a higher proportion of low complexity patients in favour of units with higher proportion of high complexity or standard intensive care patient.
7. The standard management item 13870 and 13873 benefits would increase by 12%.
8. The benefit for the high complexity item is 12% above the proposed standard item.
9. A family conference occurs in 10% of patients who currently attract benefits for 13870.
10. These changes ONLY apply to patients who have been discharged from hospital previously.

A full summary of the proposed changes with benefits are outlined in **Table 2**, and an outline of full financial projections are summarised in **Table 3**.



5. Proposed changes:

5.1 Updated definition of Intensive Care Unit:

T1. 7.1 *'Intensive Care Unit' means a separate hospital area that:*

(a) is equipped and staffed to provide , to patients admitted where required:

(i) invasive ventilation for a period of at least twenty four hours; and

(ii) invasive monitoring of intravascular pressures

(b) is supported by:

(i) an appointed director who is a specialist or consultant physician; and

(ii) at least one specialist or consultant physician who is immediately available and exclusively rostered to the ICU during normal working hours and available on call at all other times; and

(iii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iv) twenty-four hour access to pathology, blood bank, operating theatres and imaging services including CT;

(v) registered nurses with at least one registered nurse allocated to each ventilated patient and at least one registered nurse for every two patients in the ICU not receiving mechanical ventilation; and

(c) has defined admission and discharge policies.



5.2 Updated Intensive Care Management Item:

Rationale:

We have structured the 3 Tier management item systems to satisfy 4 important principles:

1. Based on the data from the Relative Value Study conducted in 1999/2000, intensive care management item 13870/73 was deemed grossly inadequate when compared with comparator group and service. Therefore a modest uplift in the main stream management items is justified.
2. To maintain current income stream for rural and regional intensive care practitioners who are likely to have a higher percentage of low complexity patients in comparison with metropolitan units, we decided to use the current \$ value of the 13870/73 (currently used for all patients) as the value for the low complexity management item.
3. The 3 management items, high complexity item, standard item (current 13870/73) and low complexity item will provide a spectrum that mimics the clinical practice of intensive care practitioners and the patients' journey through an acute episode of illness.
4. The differential between low complexity, standard management (current 13870/73) and high complexity has been set to produce an appropriate differential value that will produce a clear separation between the three management items. Whilst the low complexity has similar value to current 13870/73 for reasons described above, the standard main stream item is 12% above the low complexity item and the high complexity item is further 12% above the standard main stream management item.

We conducted a sensitivity analysis to test the effect of differing case mix with the proposed changes. The analysis confirmed that such changes would not disadvantage practitioners



who work in units with high level of low complexity case mix. A modest advantage would be seen for most intensive care practitioners.

(138AA) High Complexity: First day management

MANAGEMENT of a ventilated patient who has dysfunction of two or more organ systems in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation-management on the first day.

(see paraT1.xx of explanatory notes to this Category)

Fee: (\$ 414.50 75%= \$310.85)

(138aa) High Complexity: Subsequent management

MANAGEMENT of a ventilated patient who has dysfunction of two or more organ systems in an intensive care unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care- including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation-management on each day subsequent to the first day.

(see paraT1.xx of explanatory notes to this Category)

Fee: (\$ 307.75 75% = \$230.80)



(138CC) Low Complexity : First day management

MANAGEMENT of a patient who has no organ dysfunction and is not receiving mechanical ventilation in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation- management on the first day.

Fee: (\$ 334.55 75%=\$250.90)

(see paraT1.xx of explanatory notes to this Category)

(138cc) Low Complexity : Subsequent management

MANAGEMENT of a patient who has no organ dysfunction and is not receiving mechanical ventilation in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation- management on each day subsequent to the first day.

Fee: (\$248.20 75%=\$186.15)

(see paraT1.xx of explanatory notes to this Category)



Amendments to standard current 13870 and 13873 as follows:

13870:

MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care- including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation- management on the first day, where 1387AA and 1387CC do not apply.

Fee: (\$ 374.70 75%= \$281.00)

(see paraT1.9 of explanatory notes to this Category)

13873:

MANAGEMENT of a patient an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care- - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation- management on each day subsequent to the first day, where 1387aa and 1387cc do not apply.

Fee: (\$ 278.00 75% \$208.50)

(see paraT1.9 of explanatory notes to this Category)



5.3 Weekend and Public Holiday Loading:

Rationale:

The proposed public holiday and weekend loading is in line with afterhours loading available to other craft groups. Intensive care management items are 24-hour items, and therefore, we have excluded weekday (Monday to Friday) after hours from the proposed loading. We also restricted this loading to the management items ONLY, which dictate physical presence by practitioners and excluded other items such as monitoring items.

With the economic constraint in mind, we set the loading at 35% rather the traditional 50% used by other craft groups. Although justified, procedural items have not been included in the proposed loading.

138DD: MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and rostered for intensive care performed on Saturday, Sunday and a public holiday.

(35% Loading)

An additional amount of 35% of the fee for the management item. That is: (a) an intensive care item/s in the range 138AA – 138cc

(See para T1. yy : 1 of explanatory notes to this Category)



5.4 Family and Case Conference

Rationale:

Adequate communication with families of critically ill patients is clearly a vital component of their stay in intensive care. Other craft groups have items that support case conference and multidisciplinary care planning such as item numbers 734 – 738. If it does not include a specialist or consultant physician, the rebate is between \$75 to \$149, which increases to \$185.90 if it does include a specialist or consultant physician.

Although it doesn't include the patient for obvious reasons, case conferences and a multidisciplinary care plan is an integral part of the holistic management of an intensive care patient. This is commonly conducted to facilitate limitation and withholding treatments and for the purpose of obtaining consent for organ donation. This is why in some cases case conferences are needed more than once per day.

We believe that the proposed family and case conference will offer patients in private intensive care units access to what is considered normal practice in tertiary public hospitals.

Item (138EE) Professional attendance by an Intensive Care specialist involving a discussion with a person or persons other than the patient of not less than twenty minutes duration in the course of the intensive care management of the patient.

(Fee: \$99.0 75%= \$74.25)

(See paragraph T1: yy : 2 explanatory notes)



5.5 Prolonged Out of ICU Consultation

Rationale:

Currently, specialists and consultant physicians can use consultation item 110 (fee \$119.35). Similarly, emergency physicians can use items 515 Level 5 (fee \$196.45) and 511 Level 4 (fee \$126.85). However, intensive care specialists provide unplanned, prolonged and complex ward consultation mostly for assessment to admission to intensive care. There is no consultation item in the MBS that can be used by intensive care practitioners similar to those available for consultant physicians and emergency physicians.

Therefore we propose 2 items separated by time (less than 45 minutes and greater than 45 minutes) to be used by intensive care practitioners for services related to out of ICU consultations. These assessments include detailed history, integration of complex data, multidisciplinary consultations and family interview.

Item (138FF) Unplanned consultation out of the Intensive Care Unit for the purpose of admission to intensive care by a specialist in intensive care, for less than 45 minutes

Fee \$126.50 75% \$94.90

Item (138ff) Unplanned consultation out of the Intensive Care Unit for the purpose of admission to intensive care by a specialist in intensive care, for longer than 45 minutes

Fee \$196.45 75% \$ 147.35



6. Attachments and Explanatory notes, Figures and Tables:

Para T1.xx

Organ dysfunction²³ for the purpose of the MANAGEMENT items 138AA, 138aa, 138CC and 138cc is defined as one of the following:

Respiratory:

- i. PaO₂/FiO₂ ratio of < 300.*

Circulation: The need for one of the following:

- ii. Inotrope(s) and or vasopressors by continuous infusion*
- iii. A mechanical circulatory support device*

Renal:

- i. The need for Renal replacement therapy*
- ii. A serum creatinine level > 170 umol/l*
- iii. Urine output of < 0.5ml/kg/hr for eight consecutive hours*

Liver:

- i. A serum bilirubin level >33 umol/l*

Hematology:

- i. A platelet count <100 x 10⁹/l*
- ii. The need for the transfusion of >20ml/kg/day of red cells*
- iii. INR >2.5 in the absence of therapeutic anti-coagulation.*
- iv. WCC < 1.0x10⁹./l*

Neurological:

- i. The most recent Glasgow Coma Score in the absence of sedation is <13.*



Para T1: yy: 1

The public holiday and weekend loading is a modified item that is calculated at 35% above the fee for 138AA, 138aa, 13870, 13873, 138CC and 138cc wherever appropriate and is only claimable by a specialist or consultant physician who is exclusively available for intensive care and immediately available on call.

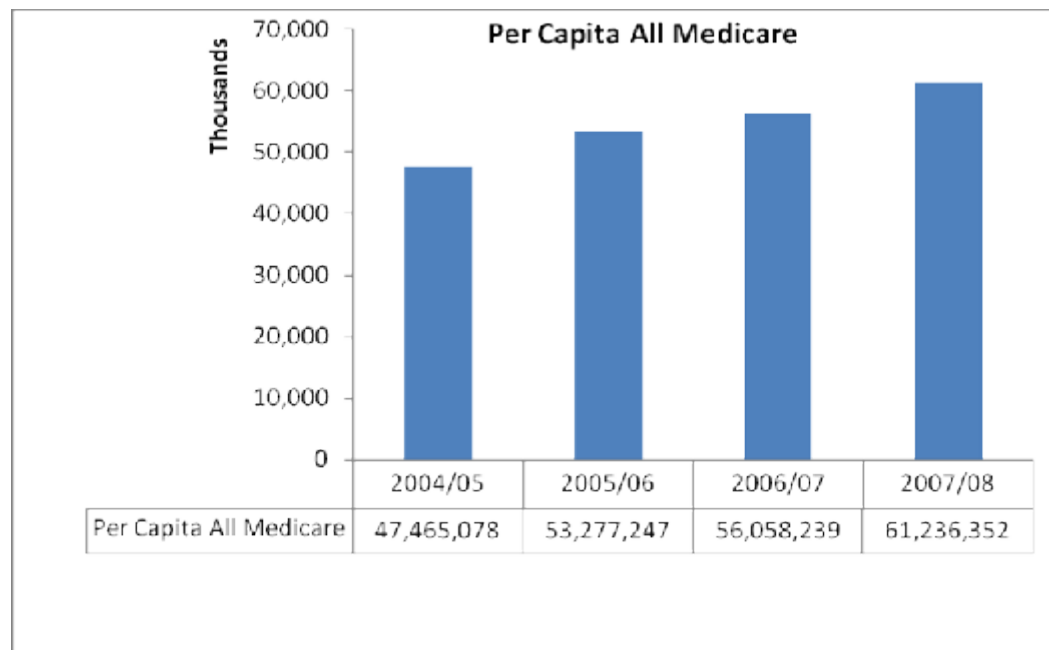
This loading is not payable to any other item.

Para T1: yy: 2

Refers to a meeting with a patient's relatives or close associates to discuss the patient's clinical status, management and future planning while in Intensive Care as well as providing counselling and support. This may include any one of multidisciplinary team of nurse, social worker, physiotherapist, dietician, primary (referring) practitioner and a religious cleric if required. The payment of Medicare benefits under this item is limited to two per patient in any 24 hour period.



Figure 1



Intensive care constitutes a very small component of Medicare expenditure, yet the discrepancy with contribution of intensive care practitioners to acute care across Australian hospitals is acknowledged by patients and peer groups alike.

Figure 2

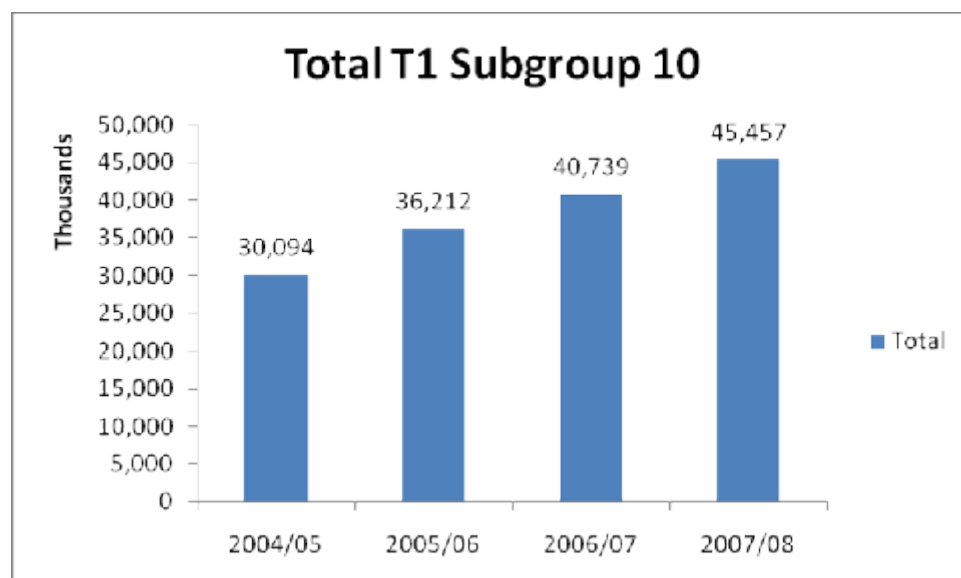
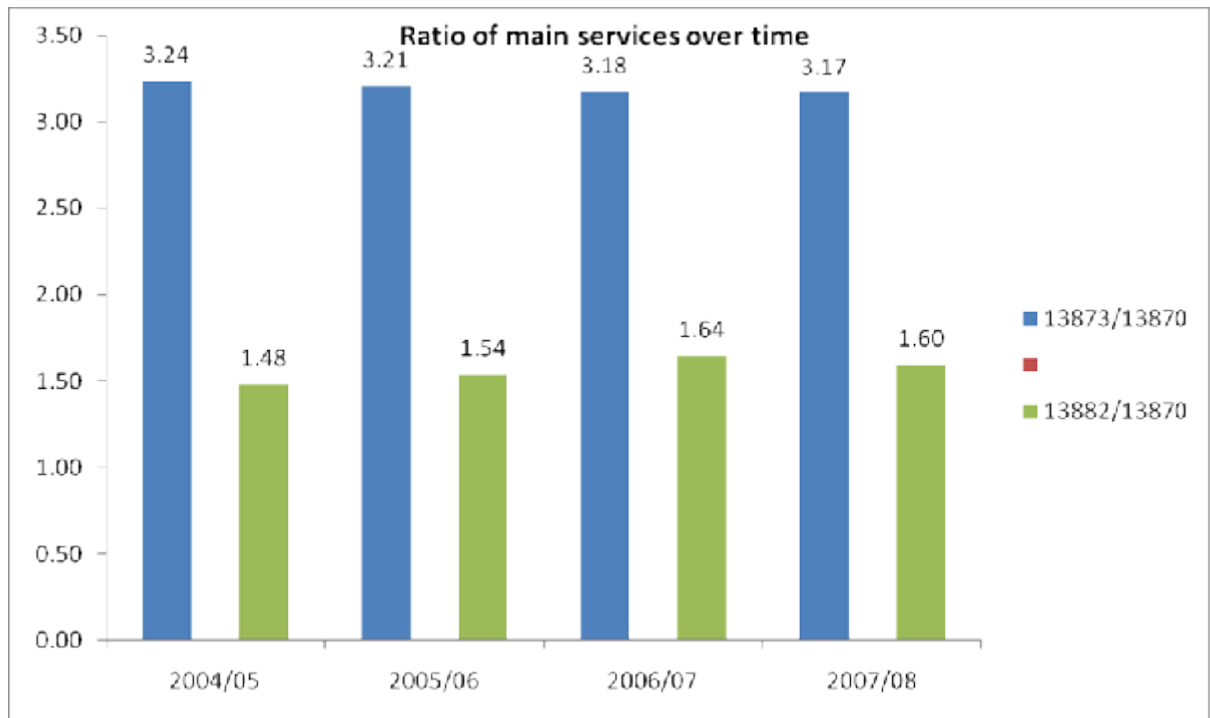




Figure 3



This graph shows the stability of intensive care subgroup 10 main items evident by the stable ratio of 13873 to 13870 and 13882 to 13870.

N.B. The increased ratio in 06/07 and 07/08 is due to the increased uptake of the item in replacement of the 13879.

Figure 4 Total benefits

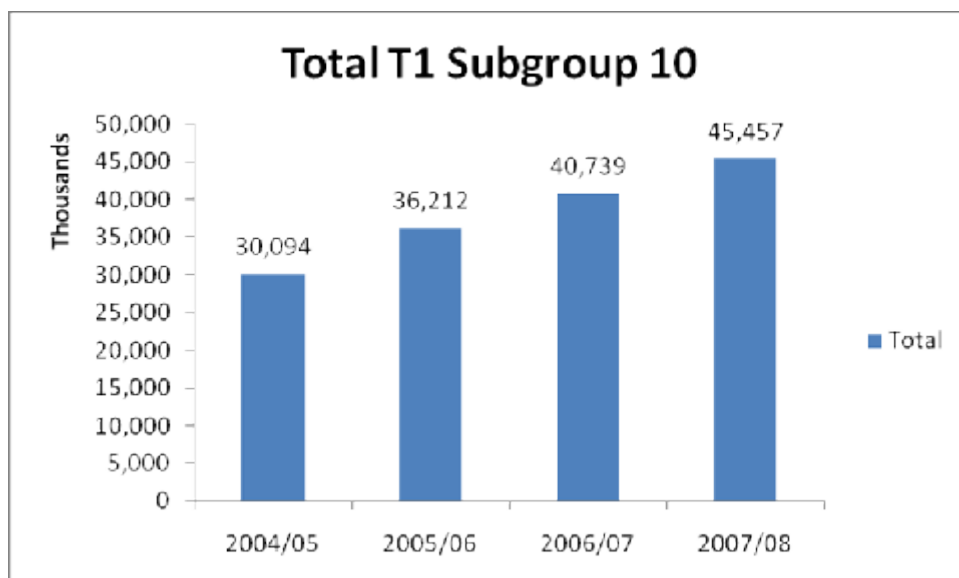




Table 1

Growth Rate of Benefits in Millions and Services Count 04 - 08						2004 -2008		
Item	Year	\$ benefits	% Growth	Services	% Growth	Benefits per 100,000 population	Services per 100,000 population	Growth per 100,000 population
13870	2004/05	5,735,840		29,864		27,437	143	
	2005/06	7,056,664	23.0%	32,804	9.8%	34,252	159	24.8%
	2006/07	8,059,153	14.2%	33,951	3.5%	38,497	162	12.4%
	2007/08	8,983,421	11.5%	37,033	9.1%	42,295	174	9.9%
13873	2004/05	13,817,160		96,662		66,093	462	
	2005/06	16,724,912	21.0%	105,255	8.9%	81,180	511	22.8%
	2006/07	18,970,098	13.4%	107,796	2.4%	90,616	515	11.6%
	2007/08	21,107,839	11.3%	117,404	8.9%	99,378	553	9.7%
13876	2004/05	7,163,957		164,158		34,268	785	
	2005/06	8,334,695	16.3%	177,311	8.0%	40,455	861	18.1%
	2006/07	8,958,359	7.5%	177,676	0.2%	42,792	849	5.8%
	2007/08	10,179,970	13.6%	197,725	11.3%	47,929	931	12.0%
13879	2004/05	1,081,267		7,764		5,172	37	
	2005/06	617,918	-42.9%	4,394	-43.4%	3,000	21	-42.0%
	2006/07	7,817	-98.7%	56	-98.7%	38	0	-98.7%
	2007/08	423	-94.6%	3	-94.6%	5	0	-86.8%
13882	2004/05	2,097,799		44,244		10,035	212	
	2005/06	3,071,992	46.4%	50,577	14.3%	14,911	245	48.6%
	2006/07	4,206,083	36.9%	55,809	10.3%	20,092	267	34.7%
	2007/08	4,563,263	8.5%	59,235	6.1%	21,484	279	6.9%
13882	2004/05	3,179,066		52,008		15,207	249	
13879	2005/06	3,689,910	16.1%	54,971	5.7%	17,911	266	17.8%
	2006/07	4,213,900	14.2%	55,865	1.6%	20,130	267	12.4%
	2007/08	4,563,686	8.3%	59,238	6.0%	21,489	279	6.8%
Growth Rate in Benefits and Services Count 04 – 08 Totals						2004 -2008		
Year		\$ benefits	% Growth	Services	% Growth	Benefits per 100,000 population	Services per 100,000 population	Growth per 100,000 population
2004/05		29,896,023		346,502		143,005	1,639	
2005/06		35,806,182	19.8%	376,279	8.6%	173,798	1,797	21.5%
2006/07		40,201,509	12.3%	382,300	1.6%	192,035	1,793	10.5%
2007/08		44,834,916	11.5%	419,516	9.7%	211,091	1,937	9.9%



Table 2

Summary of Proposed Changes			
Item numbers		Proposed benefit	P holiday loading
13870 benefits	13870	\$374.70	\$505.85
13873 benefits	13873	\$278.00	\$375.30
Weekend Pub holiday loading	138DD	Modified 35%	
High complexity D 1	138AA	\$414.50	\$559.55
High complexity D +	138aa	\$307.75	\$415.50
Low complexity D 1	138CC	\$334.55	\$451.60
Low complexity D +	138cc	\$248.20	\$335.10
Family conference	138EE	\$99.00	
Out of ICU consult < 45 minutes	138 FF	\$126.50	NA
Out of ICU consult > 45 minutes	138ff	\$196.45	NA

Table 3 is attached separately.



Appendix 1 Current descriptors.

MISCELLANEOUS	INTENSIVE CARE
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	<i>(Note: See para T1.7 of Explanatory Notes to this Category for definition of an Intensive Care Unit)</i>
13870	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - each day of monitoring for each type of pressure up to a maximum of 4 pressures <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day <i>(See para T1.9 of explanatory notes to this Category)</i> Fee: \$



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