

# The Intensivist

## “Cumque natura” - By the Force of Nature!

Every now and then Mother Nature provides evidence as to who really rules the planet (apologies to Julia Gillard and Michael O’Leary). Natural catastrophes test our preparedness to deal with the extraordinary and our resolve to survive. The beginning of 2011 witnessed weather extremes across the breadth of our country that were both testing and very humbling.

Sydney and Perth were subjected to scorching temperatures with raging fires, while Queensland and Victoria lay submerged in flood waters. Then northern Queensland was lashed by ‘Yasi’, a category five tropical cyclone, which unleashed its destructive ferocity in the early hours of 3 February.

Most of us are inclined to complain about the time-consuming drudgery of sitting through planning meetings and disaster exercises, but it was precisely these types of preparations that allowed Queensland to withstand what can only be described as an environmental assault on the state. To quote Seneca: “Luck is what happens when preparation meets opportunity”. The ability of the state to cope with the inclement conditions is as much attributed to emergency plans as it is to the camaraderie and human spirit of the ordinary man or woman in the street. Such was the enthusiasm of the Queenslanders and indeed interstate folk to assist,



*The Wesley Hospital (Brisbane) surrounded by flood waters*

that terms of endearment such as ‘mud army’, describing the hoards of volunteers pitching in to support the relief efforts, became common language.

During the floods there existed a surreal sense of humility and awe. We were reminded of our complete dependency on communal services such as roads, water and electricity. Despite beavering away in our sterile, air-conditioned ICUs, supported by generator back-up, we were not immune to the failings of services in our surrounds. The state’s largest

Hospital, the Royal Brisbane, had its main access route cut off by king tides colliding with massive volumes of water coursing their way down the Brisbane River to the sea, with patients and ambulances at times requiring redirection to alternate centres. While emergency department presentations actually decreased and ICUs weren’t burdened by excess admissions, it was staff absences, resulting from their inability to get to and from work, that taxed our health system. All the while the threat of injury and disease as a result of the flooding existed.

### ANZICS Board

M.O’Leary (President), M.White (Vice-President), A.Turner (Hon Secretary), M.Ziegenfuss (Hon Treasurer), D.Pilcher (CORE), S.Webb (CTG), S.Erickson (Paediatrics), D.Rigg (Tas), A. Holley (QLD), S.Warrillow (Vic), D.Durham (SA), D.Bhonagiri (NSW), I. Jenkins (WA), J.Liang (NZ).

Australian and New Zealand Intensive Care Society, PO Box 164, Carlton South, Vic 3053 Australia. Tel +61 (0)3 9340 3400 Fax +61 (0)3 9340 3499  
ABN 81 057 619 986 E-mail: anzics@anzics.com.au Website: www.anzics.com.au

The Wesley Hospital became an entirely isolated island in a sea of unforgiving flood waters, with the only hospital access via a tiny foot bridge across to the adjacent railway. Yet, even under these conditions, high quality intensive care continued to be delivered. As local hospital suppliers approached the point of no longer being able to provide everyday ICU products, such as bottled gases and intravenous fluids, contingencies for resupply by interstate airlifts were put into place. This requirement was averted by a mere 48 hours in one local hospital.

Of possibly greater impact on intensive care resourcefulness was Cyclone Yasi, which made landfall in northern Queensland as a category five cyclone with destructive wind gusts in excess of 280km/hr. The prospect of the arrival of Cyclone Yasi demanded the largest ever peacetime evacuation in Australian history, an incredible feat executed with style and precision. A combined civilian and Australian Defence Force response saw the evacuation of some 360 patients of varying acuity from Cairns hospitals without a single fatality. Australians may rightfully be very proud of their efforts.

There were, however, some unwelcome passengers, including the VRE silent stowaways! Of course some patients were known to be VRE colonised and were handled with relevant barrier precautions, but patients with pending microbiological investigations were treated with the general patient population in the C131 and C17 evacuating aircraft. This has resulted in the spread of VRE to some previously non-colonised patients/centres, placing a hefty burden on receiving ICUs. Repatriations of patients are still underway as north Queensland adjusts to life after Cyclone Yasi and returns to its usual workload.

There is little doubt that in the last few months many lives were saved in Queensland and few would argue that the response from the health sector was anything less than magnificent. As with all challenges, lessons are learnt and the 'Queensland big wet' is no exception. We were reminded that despite the bureaucracy at times appearing obstructive, the emergency plans were well formulated and easily implemented. It was reaffirmed that good collegiality facilitates effective emergency action and is an essential ingredient for success. We again learnt

that reliance on sophisticated machines is no substitute for good basic clinical skills. On the other hand, it is tempting to speculate that the soon-to-be instituted state-wide Clinical Information System would potentially enhance the efficiency of large-scale patient transfers. Furthermore, is it time for an Australasian-wide 'Intensive Care Antibioqram' to be established, that assists with decision making when it comes to geographical patient transfers?

Ultimately the question that needs to be asked is: "Is your ICU ready and prepared to cope with a disaster?" As we write this article the news has reported a devastating earthquake with massive loss of life in Christchurch, New Zealand. Our thoughts are with you and we are certain the Australasian intensive care community will once again band together to provide high quality care to the critically ill. We work in a truly privileged vocation.

**Marc Ziegenfuss**  
**Honorary Treasurer**  
**ANZICS**

**Anthony Holley**  
**Queensland Representative**  
**ANZICS**



Picture courtesy of the Australian Defence Force

*Emergency services personnel prepare for evacuations*

# From the President's Desk



As I write I know that we are all watching the events in Christchurch with much concern and sympathy for our New Zealand

friends and colleagues. This has truly been a remarkable summer of natural disasters and many ANZICS members will have been personally touched by the events. I know that the New Zealand ANZICS email list was used extensively in the days following the earthquake to update availability of intensive care resources across the country and hopefully this was of some help to our colleagues in Christchurch. I am sure that all ANZICS members will join me in wishing our colleagues well in New Zealand, Queensland, Victoria and elsewhere that have been touched by natural disasters in their rebuilding efforts. I am sure there are many lessons to be learnt from the responses to the disasters and I hope that we will have the opportunity to hear from those affected at our scientific meetings in due course.

As far as the Society is concerned, the summer has been spent further developing our education strategy, progressing the review of requirements to rewrite the database software for CORE, the ongoing negotiations between CORE and the Department of Epidemiology and Preventive Medicine at Monash University, and meeting with Medicare regarding the ANZICS Fees Submission.

## Education Committee

We have drawn up a Mission Statement and Terms of Reference for our new Education Committee. In brief, what is proposed is a committee that will guide and develop ANZICS's educational activities. This would include assisting the ASM Organising Committees in choosing ASM themes and appropriate speakers, development of national themed CME workshops and seminars, and acting

as a resource to Regional Chairs in the running of regional education meetings. I believe that it is important that this Committee liaises closely with CICM to ensure that activities that are organised in consideration of the College CME program and to ensure that there is not inappropriate duplication of activities. We will shortly be asking for expressions of interest from members to join the Education Committee and a Chair will be appointed.

## Developments at CORE

Following on from Professor Kathy Rowan's review of CORE a couple of years ago, it became apparent that we need a major rewrite of the CORE databases if CORE is to maintain and improve its deliverables to funders and contributors. This project has now been scoped and estimated costs range from between \$280,000 to a worst-case scenario \$500,000. While CORE retained funds would be available to cover these costs there are significant concerns within CORE that ongoing provision of IT support cannot be guaranteed within the current CORE structure. Furthermore, the Australian Commission for Safety and Quality in Health Care has published draft guidelines regarding operating principles and technical standards for Australian clinical quality registries. While these guidelines remain in a draft form, it is highly likely that the government will accept them and therefore they will, in due course, be the minimum standards accepted by funders. Under its current structure CORE does not fulfill these requirements.

For some years we have been exploring the advantages and disadvantages of relocating the CORE office to the Department of Epidemiology and Preventive Medicine (DEPM) at Monash University. DEPM has significant expertise, experience and resources for running clinical registries and currently houses over 70 clinical registries, of which some of the

largest are the Bi-National Burns Registry, The Victorian Trauma Registry, The Australian Orthopaedic and Joint Registry and The Australian Cardiothoracic Registry. Additionally, it is also the site of the ANZIC - Research Centre and the Australian and New Zealand College of Anesthetists' Clinical Trials Group. The CORE Management Committee has held a number of discussions with DEPM and the result of these is that the Committee has recommended to the ANZICS Board that CORE relocate to the DEPM offices at Monash University, adjacent to the Alfred Hospital.

The main advantages of the move are the increased IT capacity and reduced IT risk, significant financial savings (it is estimated that the database rewrite project can be conducted with CORE within the Monash University structure for approximately \$230,000 and other CORE overhead savings are estimated at around 10% per annum), academic advantages relating to the proximity to the ANZIC-RC and access to registry interest groups, statisticians and epidemiologists, and potentially better job security and professional development opportunities for our staff members. Clearly, maintenance of ANZICS branding and identity for CORE is essential. All present activities and labeling as ANZICS CORE would continue but there would be co-branding with the DEPM at Monash University.

The Board has accepted the CORE Management Committee's recommendation in principle pending receipt of a detailed proposal regarding the move and contractual arrangements with Monash University. In addition, a paper will be prepared outlining the consequences of the move for the Society and the operations at ANZICS House. I anticipate that this information will be available in four to six weeks and at that time a final decision will be made by an extraordinary Board teleconference. ANZICS members can

be reassured that the Board will act on this matter in the interests of the Society as a whole and I am confident that the final decision will lead to a significantly improved CORE with a secure future.

## ANZICS Fees Submission to DoHA

Ian Jenkins and I travelled to Canberra in January for another meeting with DoHA regarding our fees submission. We were most disappointed to be informed that the Department would not be recommending to the Minister that the submission be accepted. This was particularly irritating as much of the submission had been developed directly on the recommendation of the Department and we had previously been assured that the submission was of high quality, needed no further justification and was likely to be supported. There were a couple of small positive outcomes from the meeting in Canberra, which Ian will outline in the PricE report. In general it seems unlikely that there is any point in attempting further negotiation with the Department in the near future.

The Medicare review of pulmonary artery catheter items is still ongoing, with my appointment to the expert group extended. It looks as if the new target for the publication of the final report will be August 2011.

We were also informed during our meeting in Canberra that the Pricewaterhouse Coopers – led Health Workforce Australia review of the intensive care workforce is about to be published. This was quite a surprise as there was only a single meeting of the advisory group for this initiative in November 2009. We were assured that ANZICS would receive a draft copy of the report for our review and comment prior to the report being submitted to DoHA.

## Improving links with CICM

Current relations between ANZICS and CICM are very good but principally occur at Board level. At the recent ANZICS Board meeting it was decided that there should be

greater collaboration between the two organisations. In particular, those items identified in our Cooperation Agreement as shared activities ought to be conducted jointly where possible, rather than be performed independently by each organisation. I have already mentioned that the Education Committee will liaise closely with CICM in its activities. I think that it is important that we try to coordinate our educational and scientific meetings in order to prevent duplication of themes and invited speakers and to ensure that we are appropriately managing relationships with industry in respect of sponsorship. We are also investigating the possibility of having an ANZICS representative on the CICM Fellowship Affairs Committee to coordinate approaches to workforce and associated matters.

I am convinced that there remains a strong argument for ANZICS to be an independent organisation separate from CICM. We are particularly keen to ensure that we represent and give voice to those specialists in intensive care that are not Fellows of CICM and will continue to act as an advocate for these members in our relationship with CICM. Nonetheless, I know that many members of the intensive care community believe that we should continuously strive to ensure that we maximise synergies with CICM to limit costs to members. With the proposed relocation of CORE, the staff complement at ANZICS House will be significantly reduced and this again raises the option of relocating the rest of the Society to share the CICM building in Prahran. We had been in negotiation with the owner of the building regarding taking tenancy of the second floor; however, this space is no longer available. There remains some additional space leased by CICM that might be available and we will continue to liaise with the College regarding this.

## Rural intensive care practice

Representing rural intensive care practitioners has been the remit of a joint JFICM/CICM and ANZICS

committee. Despite the involvement of a number of enthusiastic individuals over the years, it has appeared difficult for this committee to gain traction. Part of the problem, I think, has been a failure of the two organisations to set specific goals for the committee. Late last year the co-Chairs of the committee submitted their joint resignation. I would like to take this opportunity to publically thank Dr Penny Stewart and Dr Gerard McHugh for their hard work in attempting to drive the committee forward. Their resignation has certainly put the matter back on top of the agenda for both ANZICS and CICM and the matter was discussed at the recent Board meetings. As a first initiative we propose to create an ANZICS rural practice special interest group by initially enrolling all ANZICS members with a rural membership address. These members will be enrolled into a new ANZICS rural practice email list (opt-out will be available) and from this we would hope to recruit a new Rural Practice Committee. We will be liaising closely with CICM in this initiative and will also be approaching ANZCA and ACEM to try to identify rural intensive care practitioners that are Fellows of those colleges. We will also ensure that there is a clearly nominated ANZICS Board member acting as a link between the Rural Practice Committee and the Board.

## ANZICS Linkpersons

The ANZICS Linkperson list has been finalised and I would like to thank everyone who has volunteered. The Board hopes that Linkpersons will endeavour to ensure that ANZICS activities become a regular discussion item on the agenda of departmental management meetings in order for Society activities to be more responsive to members' requirements and ensure that early feedback is available for new initiatives we undertake. We would encourage communication from members to the Executive and Board to pass via Linkpersons to the Regional Chairs and/or directly to the Executive. The Regional Chairs

will also use the ANZICS Linkpersons to advertise regional activities such as evening meetings and seminars. Another role that we hope Linkpersons will embrace is recruitment to the Society. We encourage Linkpersons to recommend ANZICS membership to new CICM advanced trainees and to ensure that all specialists within their departments are full ANZICS members. We have established an ANZICS Linkpersons email list that will be used from time to time to disseminate information directly to Linkpersons. We are investigating the feasibility of running a Linkpersons breakfast or lunch at the ASM this year at which Linkpersons attending the

meeting can provide direct feedback to the Executive regarding this new role.

### Other matters

I would like to remind members about the ANZICS Honour Roll. This is a list established on our website to recognise ANZICS members who have contributed above and beyond to the development of the specialty. Please submit nominations for inclusion to the Honour Roll via Regional Chairs.

Registrations for the Singapore-ANZICS Intensive Care Forum at Easter are now well past the meeting's 'break-even' point, ensuring that this new initiative will be a success. If you have

not registered there's still time to do so. Log on to the website ([www.sg-anzics2011.com](http://www.sg-anzics2011.com)) and I will see you all in Singapore!

Despite a bit of dampness affecting the Brisbane Convention Centre all is OK for the ANZICS – ACCCN ASM in October. The Organising Committee have put together a very stimulating scientific program and I recommend that you put the dates in your diaries now (13-15 October, 2011). Please also remember the winter Safety and Quality and CTG meetings in the Hunter Valley (2-5 August, 2011).

**Michael O'Leary**  
ANZICS President

## General Manager's Report



2011 is already shaping as a busy year for ANZICS. Following a short break over the holiday period, we welcomed in the New Year amid a flurry of

activity across the Society. The Board came together in February for another productive meeting and each of the committees launched into the New Year by continuing to work on existing projects and exploring new initiatives and we look forward to hearing of the outcomes of such programs .

We will shortly be circulating a call for expressions of interest for positions on the ANZICS Education Committee. The Committee was formed following the Board's strategic planning workshop last year and is responsible for guiding and developing all ANZICS educational activities through the support and promotion of both new and existing educational programs and initiatives. I encourage you to give some thought to becoming involved in your Society by joining committees such as this.

Speaking of educational activities, we have a number of events coming up this year, starting with the CTG in

### Future Events

#### ANZICS New Zealand Regional Conference 2011

31 March-1 April, 2011  
Bayview Wairakei Resort, Taupo, New Zealand  
[www.anzics2011.org.nz](http://www.anzics2011.org.nz)

#### Intensive Care Medicine (ICM) Course

14-17 July, 2011  
Melbourne  
[www.anzics.com.au](http://www.anzics.com.au)

#### Singapore-ANZICS Intensive Care Forum

22-24 April, 2011  
Suntec Singapore International Convention Centre, Singapore  
[www.sg-anzics2011.com](http://www.sg-anzics2011.com)

#### Safety Quality Audit and Outcomes (SQAO) 2011

1-3 August, 2011  
Hunter Valley, NSW  
[www.sqao2011.com](http://www.sqao2011.com)

#### CTG Winter Research Forum

4-5 August, 2011  
*\*in conjunction with SQAO*  
Hunter Valley, NSW  
[www.anzics.com.au/ctg/ctg-scientific-meeting](http://www.anzics.com.au/ctg/ctg-scientific-meeting)

#### ANZICS/ACCCN Annual Scientific Meeting 2011

13-15 October, 2011  
Brisbane  
[www.intensivcareasm.com](http://www.intensivcareasm.com)

Noosa, which should be underway by the time of you reading this. Australia is honoured to host the 6th World Congress on Paediatric Critical Care in Sydney next week. The Singapore-ANZICS Intensive Care Forum is almost upon us and I encourage you all to register and attend. The Organising Committee has put together a most impressive scientific program. It is also a fantastic opportunity to combine an educational experience with travel over the Easter holiday. Visit [www.sg-ANZICS2011.com](http://www.sg-ANZICS2011.com) to register now.

The Intensive Care Medicine Course is being held in Melbourne in mid-July. The course continues to draw an increasing number of delegates and

receives positive feedback each year. Registrations open on 15 April, visit [www.anzics.com.au/icmcourse](http://www.anzics.com.au/icmcourse) for further information.

The Safety Quality Audit and Outcomes (SQAQO 2011) conference is being held in the Hunter Valley in August, again in conjunction with the CTG Winter Research Forum. Keep watching the website: [www.sqao2011.com](http://www.sqao2011.com) for information on registration, call for abstracts and the scientific program.

In ANZICS House news we recently farewelled Linda Gatehouse (Project Manager) and we wish her well as she welcomes a new addition to her family in the coming months. We also farewelled Chris Nash (Executive

Assistant) in late February when he commenced further study. We also extend our congratulations to Shaila Chavan (Project Officer – Data Quality & Education) and her family, who welcomed a healthy baby girl Siona earlier this month.

Once again I would like to take this opportunity to remind members to pay their subscription as we will be sending out renewals for 2011/12 in the coming months. Membership is integral to the continued success of the society and timely payment, along with the steady growth of members, ensures that this success can continue into the future.

**Erin O'Sullivan**  
**General Manager**

## Regional Reports

### New South Wales

NSW ANZICS has been quite dynamic over the last few months. We have conducted three CME sessions since the last report, each of which was well attended. A combined CICM- ANZICS session to review the minimum standards for ICUs was also well attended and generated robust discussion on the changing face of ICUs and the role of intensivists. In particular there was debate about the concept of high dependency and the usual lack of consensus of what it meant from an intensivist's perspective. On 24 February the concepts of futility and social justice in end-of-life care decision-making were discussed. The ICU team from St George Hospital coordinated this session that attracted participants from regional and outer metropolitan areas of NSW. The forum was very informative and the cases discussed highlighted the need for further discussion and education on this issue. We plan on having bi-monthly CME sessions in NSW and hope that all NSW ANZICS members attend at least two sessions this year.

I am heartened to see the increased interest in ANZICS activities by trainees and new Fellows. As you can see below, ANZICS conducts a wide variety of activities for intensivists and intensive care. Please contact me or one of the committee members below if you would like to be part of an ANZICS committee.

#### **ANZICS NSW Regional Committee:**

Chair: Deepak Bhonagiri  
Members: Mark Nicholls,  
Mark Lucey, Michael O'Leary

#### **ANZICS Committee Representation, NSW:**

Executive:  
Michael O'Leary – President  
PRiCE Committee:  
Mark Nicholls – Member ANZICS  
CTG: Ian Seppelt,  
Peter Harrigan ANZICS  
S&Q Committee:  
Tony Burrell – Chair  
ANZICS CORE: Tony Burrell  
ANZICS Organ and Tissue Donation  
Committee: Deepak Bhonagiri

**Deepak Bhonagiri**  
**New South Wales Chair**

### Queensland



It is a privilege to deliver my first quarterly report as the Queensland Chair and I would like to take this opportunity to thank Marc Ziegenfuss for a job well done.

Queensland has kicked off the year with a sequence of catastrophic natural disasters. First there were the south-east Queensland floods, which witnessed the tragic loss of life and massive property destruction. This was followed closely by 'Yasi', the category five cyclone which made landfall in northern Queensland in the early hours of 3 February. Incredibly there was no loss of life directly attributable to the cyclone, which bears testament to the amazing efforts of the Queensland emergency services involved in the operation before, during and after Cyclone Yasi.

Throughout this tumultuous period we witnessed a tremendous spirit of cooperation between all the ICUs in south-east Queensland. They were forced to deal with access difficulties and staff limitations and had to prepare for potential multiple casualties as well as receive critical care patients who had been evacuated from the north. It is

events such as these that clearly demonstrate the value of cooperation, recurrent disaster exercises and forward planning. Congratulations to all the intensivists in our state who contributed to such a remarkable outcome.

On the scientific front, Queensland investigators have some very exciting times ahead. The Statin trial is in its final stages and will be presented at the Noosa CTG meeting and in Brussels, as we eagerly await the results. We are also very proud of the Queenslanders who are principle investigators in the ESCAPE trial, which has secured a \$3.2 million NHMRC grant to settle the question of steroids in sepsis.

The implementation of the Clinical Information System across Queensland ICUs continues to be an exciting development that will ultimately make real-time data sharing a practicality across our specialty.

Brisbane is hosting the ANZICS ASM in October 2011. With the meeting fast approaching the Conference Committee has been hard at work to deliver what promises to be a very exciting scientific program and entertaining social agenda. We urge all members to mark this meeting in their diaries and plan for an educational and fun getaway to the subtropics. I look forward to seeing you all in Brisbane in October 2011.

### **Anthony Holley Queensland Chair**

### **South Australia**



The SA AGM will have been held between the writing of this and your reading it. Again it will have been held in conjunction with the CICM AGM, as we have

been doing regularly in SA. In a small state with a tight-knit ICU community it seems excessive to have separate meetings and the Society and the College seem to work well together. Discussion at the recent ANZICS Board meeting in February suggest this isn't always so; perhaps anyone reading this could have a think about how they would like the two to interact and feed this back to me or their hospital

Linkpersons. We can then introduce some democratic feedback into future discussions. In the meantime, as Regional Chair for ANZICS I have been seconded onto the Regional Committee of CICM.

The annual Tub Worthley Travelling Scholarship is again planned for late May/early June (date to be confirmed), giving registrars an opportunity to present their projects and compete for a worthwhile prize of air tickets and cash.

The ASM is coming to Adelaide in 2012 and planning is underway, with Ken Lee as Convenor. Adam Deane will be Scientific Convenor and Bernadette Grealy will be Nursing Convenor. Mary White and Sandy Peake will be advisors and mentors. Volunteers for Social Convenor were easier to obtain and Nick Edwards and Alex Wurm emerged from the resultant scrum to begin an arduous training program of intensive wine tasting and restaurant reviewing.

#### **Office Bearers:**

Chair: David Durham

Vice Chair: Ken Lee

Secretary: Adam Deane

Treasurer: Adam Deane

#### **Representatives on committees:**

CTG: Sandy Peake

Abstract Review: Marianne Chapman

PricE: Nick Edwards

Safety and Quality: Brett Sampson

CORE: John Moran

DODC: Stewart Moodie

Australian Resuscitation Council:

Stuart Baker

### **David Durham South Australian Chair**

### **Victoria**

Victorian activity is currently focussed on educational pursuits, with a number of meetings scheduled for 2011. The first of these was held on 28 February and adopted an infectious diseases theme. For quite some time there has been considerable work to address the problem of nosocomial infections in the critically ill. It now seems that we should also pay attention to the emergence of multi-drug resistant pathogens in the community. Two of Melbourne's leading

ID researchers provided an update on the impact of these complex microbiological problems for ICU clinicians. Paul Johnson described the phenomenon of community acquired MRSA and its potential impact on ICU and Patrick Charles shared his insights on trends in community acquired pneumonia. The Royal Melbourne Hospital Department of Intensive Care generously hosted the educational event and a good attendance of local intensivists was achieved.

### **New Zealand**



The NZ Regional ANZICS Conference for 2011 will be hosted at the Department of Critical Care Medicine, Auckland Hospital. This will be held in Taupo, from

31 March – 1 April. It has an excellent selection of speakers and topics, which will ensure there is something of interest for everyone.

The ANZICS/CICM ICU Registrars' Conference will be held by Waikato Hospital (its place of origin) with the dates likely to be in the second half of 2011.

Ywain Lawrey is the first NZ representative on the ANZICS PricE committee. As PricE previously concentrated on issues relating to private intensive care financial practice, it was primarily concerned with Australian intensivists. However, it will now consider such issues as work/life balance and intensivist well-being, hence the need for NZ representation.

Auckland is starting up a Regional Intensive Care Medicine Training Scheme as the increasing number of ICM trainees warrants a formal approach rather than the previous ad-hoc arrangements.

There has been discussion about how intensivists can improve their relationships with the new coronial system. If you have concerns or thoughts about this, please discuss via the mailing list or with the ANZICS Executive.

Finally, one's thoughts are with Christchurch and our colleagues based there, given the terrible earthquake that has taken place.

### **Janet Liang New Zealand Chair**

## Membership Report



Recent natural disasters in Queensland, Victoria and Christchurch highlighted the importance of the Society's

ability to support its members. With limited resources and communication channels during the natural disasters, ANZICS members turned to their regional lists to offer their support and assistance to colleagues in affected areas. This demonstrated to both members and non-members working in intensive care the importance of a specialist society such as ours.

As a member and honorary Secretary of ANZICS I know too well the importance of each and every member and the value of their

continued support of our Society. Your membership ensures our viable future and enhances our ability to act as a Society to support you as an individual and group working in intensive care. Our membership numbers are continuing to grow each year, but I ask, on behalf of the Board and myself, that all of our members continue to assist ANZICS in promoting membership. A successful membership drive guided by the Society's staff in 2010 resulted in the membership database being updated to include all current contact details and the financial status of each member.

I look forward to working together with all of our members to grow our Society and ensure its future in supporting intensive care.

**Dr Andrew Turner**  
**Honorary Secretary**

## Membership

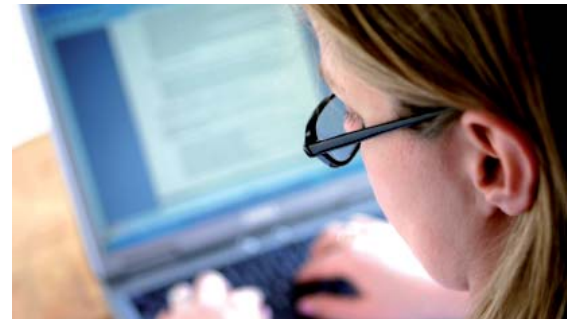
Welcome to the following new ANZICS members:

Dr Laura Bainbridge  
Middlemore Hospital NZ

Dr Sean Chan  
The Canberra Hospital ACT

Dr Maziar Razavian  
Central Coast Health Service NSW

Dr Sheila Hart  
Wellington Hospital NZ



## Clinical Trial Group (CTG) Report



The current highlight for the ANZICS Clinical Trials Group is the Noosa meeting, which will be underway at the time of you reading

this. The guest speaker is Professor Jeffrey Drazen, Editor-in-Chief of the *New England Journal of Medicine*, who will travel from Boston to attend the meeting. This is a huge coup for an intensive care research group based in Australia and New Zealand. I am extremely grateful to Simon Finfer who first approached Professor Drazen about the possibility of attending. The meeting will also include the first presentation of the results of the DECRA, STATINS, and PROTECT trials. These are all landmark studies, the results of which are eagerly awaited by clinicians and researchers throughout the world.

For the first time, this year we were not able to accommodate all requests

to present new projects at the Noosa meeting. While this was disappointing, especially for those investigators who have had their presentations delayed until the Winter Research Forum (which will be held in the Hunter Valley on 4 - 5 August), it demonstrates the growing interest in research and the number of new projects that are being developed by the CTG.

One of the key activities outlined in the 2010-2013 Strategic Plan (available at [www.anzics.com.au/clinical-trials-group](http://www.anzics.com.au/clinical-trials-group)) was revision of the CTG's Terms of Reference. It had become apparent that the principles and policies that governed the CTG were in need of an overhaul and update. The new Terms of Reference have now been released and are also available on the CTG website.

All major stakeholders, including the management committees of all CTG endorsed studies, the ANZIC-RC, and the Critical Care and Trauma Division of the George Institute have had the

opportunity to provide feedback about the new Terms of Reference. Key changes include endorsement application deadlines with longer lead-times before NHMRC grant submission, mandatory inclusion of review by a Research Coordinator for all new projects, addition of a panel of clinician reviewers who are not members of the CTG Executive, a standardised procedure for allocating Chair-delegates to oversee endorsement applications where a conflict of interest can be identified, and much greater emphasis on feasibility and site impact as well as scientific validity. I'd like to thank Colin McArthur and Sandy Peake who led the process of revision on behalf of the CTG Executive.

Five CTG endorsed studies have been submitted to peak funding bodies in Australia and New Zealand so far this year. The ARISE Investigators have requested 'top-up' funding for their RCT of Early-Goal Directed

Therapy. Recruitment into ARISE is now proceeding well but because study completion will be delayed by approximately 18 months, additional funding is being requested. The PHARLAP investigators have submitted an application to the NHMRC for funding of a phase II study of a ventilation strategy that aims to optimise lung recruitment in patients with ARDS. The BLING investigators have also submitted to the NHMRC for funding for a phase II trial of administration of beta-lactam antibiotics by infusion, compared with bolus administration, in patients with severe sepsis. The largest NHMRC grant application is for the TRANSFUSE study of freshest available versus standard issue red cells in ICU patients who require transfusion. I'm particularly pleased that a group of predominantly New Zealand investigators led by Paul Young have submitted an application to the New Zealand HRC to fund the

HEAT study. This is a phase II study of permissive compared with aggressive management of fever in patients with severe sepsis. Although the HRC has supported CTG studies previously, this is the first occasion when this body has been approached as the lead funder. There are currently 19 CTG endorsed projects that are either active or have applied for funding.

All ICUs will have recently been approached to renew their membership or become a member of the CTG. The 'good works' of the trials group are totally dependent on membership subscriptions and the outputs of the CTG (\$45 million in research funding to our ICUs and five manuscripts published in the New England Journal of Medicine) bear testament to the value created through membership. Please note that the current invoices are for 18 months of membership and that no further invoices will be issued until July 2012. The annualised amount

of the membership fee has not changed. This will allow the CTG to align its reporting, budgetary, and income years and I thank you for your tolerance during this transition period.

I'd like to advise all members that regions will need to identify their nominee to the CTG Executive Committee in July this year following elections of CTG Office Bearers at the June CTG Executive meeting. Regional representatives serve renewable two-year terms and are appointed to the CTG Executive by each Regional ANZICS Committee.

Finally, on behalf of all members of the CTG I would like to extend my sincere condolences to our colleagues in Christchurch following such a shocking tragedy. Our thoughts and best wishes are with all who have been affected.

**Steve Webb**  
CTG Chair

## ANZICS CLABSI Prevention Project

This project is funded by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and aims to reduce the Australian CLABSI rate to <1/1000 line days. As an adjunct to this, we are also promoting consistent national surveillance and reporting to enable accurate measurement of CLABSI rates and providing timely reporting and national benchmarking opportunities that are not currently available.

The adoption of consistent national surveillance is supported by work being done at the ACSQHC and by the ACHS CLABSI Clinical Indicator being updated in January 2011. The CLABSI clinical indicator has also moved from infection control to ICU ([www.anzics.com.au/safety-quality/achs-indicators](http://www.anzics.com.au/safety-quality/achs-indicators)).

We are currently in the last stages of preparation, which involves website development and the establishment of a national database. As all project resource materials will be online, implementation will not commence until the website is functioning, which

unfortunately will not be until after Easter. However, this allows the sites to establish a baseline CLABSI rate by commencing surveillance if they are not already doing so.

### Implementation

All ICUs and associated infection control units will be invited to send representatives to a one-day 'learning session' in their jurisdiction. These will include an overview of:

### Why...

- The science of CLABSI.
- Surveillance definitions and reporting.
- Other successful prevention projects.

### What and how...

The ANZICS CLABSI Prevention Project

- Insertion protocol and checklist.
- Maintenance protocol.
- Communication, sharing and support.

We hope that speakers will consent to being filmed so that the sessions can be viewed on the website.

We look forward to working with you on this important project to improve patient outcomes.

**Gabrielle Hanlon**  
Project Manager  
03 9340 3492  
[gabrielle.hanlon@anzics.com.au](mailto:gabrielle.hanlon@anzics.com.au)



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# CORE Report



As this is the first Intensivist of 2011, it seems only right to review the many achievements of the past year and preview some of the upcoming

developments. There were many changes at CORE in 2010 and there are more to come in the year ahead.

Almost 480 reports have been returned to individual sites from the APD over the past year and are available for viewing via the ANZICS CORE portal (<http://sasspm.anzics.com.au/Portal/displayLogon.do>). Please liaise with your ICU Director or CORE contact if you don't know your log-in details. Regional reports have regularly been going back to Jurisdictional Liaison Committees in New South Wales, Victoria, Queensland, and South Australia. We encourage all other areas of Australia and New Zealand to set up similar bodies with their local health departments for the purpose of reviewing intensive care outcomes. After taking a break last year during the H1N1 epidemic, data collection for the 09/10 Critical Care Resource Survey is nearing completion; if you are one of the few sites yet to submit your survey please do so as soon as possible. There have been five major annual reports and nine scientific publications in peer review journals using CORE data, with at least three more accepted for publication this year. In addition, ANZPIC data will be displayed in several presentations at the upcoming Paediatric World Congress. Almost all ANZPIC sites were audited last year and the APD Data Audit Program entered its second cycle, visiting units in New South Wales and Victoria. Both the ANZPIC and APD data audit programs continued in 2010.

Amid the considerable amount of 'routine' activity, there have been a number of personnel changes at CORE. During 2010 Graeme Hart stepped down from his position as the long-term Chair to assume the role of Director of the Austin ICU. The new management

committee, consisting of myself, Peter Hicks, Anthony Slater, Erin O'Sullivan and Gail Adams, is coming to grips with the huge task he previously bore. A number of CORE staff have also moved on; including most recently Kelly Drennan and Marcela Forero Duarte, who, for the past few years, had been in charge of the CCR Survey and CORE data management systems respectively. We wish both Kelly and Marcela the very best in their new endeavours and appreciate all their hard work. Shaila Chavan is also away from the office, albeit temporarily, on maternity leave and we wish her all the best with her growing family. Gail Adams has settled in well to her role as manager of CORE. Tamara Bucci, under the expert guidance of Allison van Lint, is now very productive in her position auditing sites. Jostein Saethern continues to provide support and development to run AORTIC, while assisting with all other in-house IT queries. Jan Alexander in the Brisbane office continues to produce and manage a high quality output for all paediatric units, with ongoing support from Shelley Tregga.

New research developments throughout the year included Eldho Paul commencing his PhD studies through Monash University, developing a new mortality risk prediction model for adult patients admitted to Australian and New Zealand ICUs, collaborating with the BEAMS (Burns Evaluation And Mortality Study) investigators to develop mortality prediction models for burns patients in Australasian ICUs and the development of the new international Paediatric Index of Mortality model – PIM3.

While a few short paragraphs can summarise the outputs from CORE over the past year, it belies the huge amount of work contributed by the staff at CORE and by all the researchers and project officers working with CORE. To all of you, I say a massive thank you.

There are, however, more developments afoot at CORE. The Triennial Funding Agreement has been submitted to the jurisdictional governments who fund

ANZICS CORE activities. The majority of areas have already confirmed commitment for another three years, with an additional one-off top-up payment for upgrading CORE's IT infrastructure. CORE is also currently in negotiations with the Australian Commission on Safety and Quality in Health Care to provide the data and reporting processes to monitor central line associated bacteraemias throughout Australia.

In finishing, I would like to ask all ICU doctors and nurses to volunteer their units for the ANZICS CORE APD data audit. Participation in the audit is voluntary, but we already know that overall quality of data from audited sites is good. The highest quality data comes from sites with dedicated and trained data collectors and the problem area is the coding of GCS and chronic health variables. It is only through auditing the remaining sites that we can hope to garner a comprehensive understanding of all the data quality issues affecting the information you send to CORE and enhance our ability to provide reports which compare your mortality outcomes to other hospitals.

For example: We can be pretty certain that the hospital who submitted the seven-year-old boy weighing 2305kg with no diagnosis who was discharged home represented a data error ('0' is pretty close to the decimal point on the keyboard after all). However, was the 516kg woman who underwent a laminectomy a reality? Possibly not. Was there really a woman aged 110 years who was admitted following a GI bleed and was discharged alive to another hospital? Possibly yes. Only by participation in the audit can we ever know. Please join in the audit (particularly South Australian and Tasmanian ICUs, who will be visited next) and contact Allison van Lint at ANZICS CORE for more information.

Thank you and I look forward to the next report.

**David Pilcher**  
**Chair, ANZICS CORE**

# ACHS Intensive Care Indicators Version 4 Update

The ACHS Intensive Care indicator set was revised in 2010, with Version 4 implemented into the collection as of 1 January 2011. While some indicators were modified and indicator 3.1 (unplanned re-admissions to the ICU) was deleted, three new areas were developed.

## Area 2 Intensive Care Patient Management

This area contains an indicator addressing recognising and responding to clinical deterioration of adult patients within 72 hours of being discharged from an ICU.

## Area 4 ICU Central Line-Associated Bloodstream Infection (CLABSI)

This area contains an indicator that was previously included in the Infection Control indicator set and addresses adult ICU-associated CI-CLABSI and PI-CLABSI.

## Area 6 Minimum Standards for a Rapid Response System (RRS)

This area contains five indicators that were developed in conjunction with the Essential Elements for Recognising and Responding to Clinical Deterioration National Consensus Statement from



the Australian Commission on Safety and Quality in Health Care. The indicators address rapid response system calls, cardiopulmonary arrests and deaths (NFR and non-NFR) within the healthcare organisation (not just the ICU).

The Intensive Care Indicator Working Party members were aware that the indicators had to be relevant to all healthcare organisations, regardless of size or service type. The user manual describes a rapid response system as

any system that provides emergency assistance to a patient whose condition is deteriorating and includes a variety of systems, such as medical emergency teams, critical care outreach, intensive care liaison nurses, contacting local health professionals such as general practitioners and ambulance services and so on.

Any comments on the revised Intensive Care Version 4 can be directed to Dr Jen Bichel-Findlay via [jbichel@achs.org.au](mailto:jbichel@achs.org.au) or 02 8218 2727.

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## Death and Organ Donation Committee (DODC)



The content of a revised ADAPT course has now been finalised in collaboration with the Australian Organ and Tissue Authority.

The revised course will have a little more pre-reading and a web-based pre-test that will be completed before the face-to-face workshop that forms the core of ADAPT. The workshop will now have less didactic lecture content and greater opportunity for focussed discussion and role-plays. Feedback on the revised ADAPT is welcomed and, as always, it is expected to

evolve over time. Arrangements for courses outside Australia are expected to continue without any effect on participants, though the bereavement component is still to be finalised. It is expected that the ADAPT course will be delivered in the new format from early 2011.

A work plan for revision of the ANZICS Statement on Withholding and Withdrawing Treatment has been developed. The revision is likely to consider issues around end-of-life care more broadly and will be carried out by a Working Group from this Committee, along with other co-opted members, under the leadership of Bill Silvester.

Other work being carried out by the Committee is the ongoing review of sections of the ANZICS Statement on Death and Organ Donation. As stated in the preface, this is a living document with the most recent and definitive version being that which appears on the ANZICS website.

We continue to be open to requests to fund educational projects related to organ and tissue donation. Expressions of interest should be sent to the ANZICS Secretariat.

**Prof Geoffrey J Dobb**  
**Chair, DODC**

# Paediatrics Report



Firstly, on behalf of the paediatric ICU community, I would like to send my best wishes to those affected by the recent floods, cyclones,

bushfires and earthquakes throughout Australia and New Zealand, particularly to all our colleagues in Queensland and Christchurch who have been the hardest hit in the last few months. Given the extent of natural disasters in Australia and New Zealand this summer, many of us will know someone deeply affected.

There has been a lot of activity on the paediatric front in the past few months.

The 6th World Congress in Paediatric Intensive Care is taking place in Sydney in March. The PICU community is very excited as this is a once in a lifetime opportunity for Australia. We are all hoping that this will be a highly successful event and our thanks go to the Organising Committee, particularly David Schell and Tina Kendrick, who have put in an enormous amount of work.

Below is a brief summary of the activities over the past few months.

## 1. Paediatric Study Group

- a) Cool Kids: Randomised trial in paediatric traumatic brain injury. Multi-national, funded by NIH. Ethics approval and contracts agreed upon at all Australasian sites. Study has commenced in Australia and New Zealand.
- b) Safe-EPIC proposal: Three-day point prevalence study completed in December 2009 to assess resuscitation fluids used in PICU. Dr Marino Festa is the PI and will perform statistical analysis on this work with the aim to stage an eventual international point prevalence study. ANZICS has provided a seed grant of \$10,000, which has allowed Rino to continue his work.

- f) CLOTS study: Randomised trial of heparin versus placebo to prevent thrombosis and infection in central lines in PICU. All participating centres (Women's and Children's (Adelaide), Royal Children's (Brisbane) and Princess Margaret (Perth)) have ethics approval and have commenced. The study is funded by a grant from the South Australian Women's and Children's Hospital Foundation. Dr Michael Yung is the PI.

- G) Paediatric H1N1 study: Collaboration between the INFINITE investigators, Paediatric Study Group to report on the PICU burden of the H1N1 pandemic. Manuscript has been accepted for publication in Paediatrics.

Michael Yung, who has been in the Chair for four years, will be stepping down, so a new Chair will need to be nominated and elected.

## 2. ANZPIC Registry

2008 ANZPIC report has been released. I would like to thank Jan Alexander and Tony Slater for all their work.

Proposals at last Paediatric Study Group meeting included:

- a) PICUs will be identified in future reports.
- b) Audit proposal to look at accuracy of RACHS (cardiac surgical risk categories) coding (agreement with coding by cardiac services).

## 3. World Congress Sydney 2011

The scientific program has been finalised (including reserve speakers) and sponsorship plans are going well (100% of projected confirmed).

Online registrations and abstract submission now operational. Website includes scientific program, accommodation, social program, and satellite courses.

There will be a study day prior to the conference with all international paediatric research groups meeting to discuss collaborative research.

## 4. Brisbane ASM

The Brisbane ASM will be held in October 2011. The ASM will include a paediatric component and international speakers have been confirmed.

## 5. Meeting with RACP (17th February)

As the paediatric representative for ANZICA I was invited to attend a meeting with the Paediatric and Child Health Division Council of the RACP. They invited representatives for all paediatric special societies and groups with some relationship with the RACP. I also represented the CICM. Issues discussed mainly centred around training and access to appropriate training posts for CICM trainees. The RACP was very constructive and hopefully, by working together, we can optimise the training experience in paediatric intensive care.

## 6. Inhaled Nitric Oxide

An application for nitric oxide to be funded as an orphan drug by the Federal Government for use in neonatal and paediatric intensive care for limited indications has been submitted.

This issue continues to develop with high level meetings continuing. Ikaria (patent holder) has put in the submission to the Federal Government and this has been tabled in parliament. I have been contacted recently by Mr Shayne Neumann, who is the federal member for Ipswich in Queensland and he has taken up the cause. The meeting is still to be arranged.

## 7. Oceania representative for WIFPICS

Dr Stephen Jacobe has been elected as the Oceania representative on the World Federation of Paediatric Intensive Care (WIFPICS) Board.

Our thanks go to Dr Jonathan Gillis who has performed the role up until now.

**Simon Erickson**  
**Chair, Paediatrics**

# PricE Committee Report



## Submission to Medicare:

In June 2009 ANZICS filed a submission with the Department of Health and Ageing

(DoHA) with respect to Medicare rebates for ICU service items.

Despite multiple communications, both verbal and written, between DoHA and the then Chair of PricE Committee (Dr Yahya Shehabi) and the subsequent PricE Chair, Associate Professor Michael O'Leary, no progress was made in terms of securing an agreement in 18 months, even though DoHA assured us that the submission was strong and they were confident that it would be accepted.

On 28 January this year Michael O'Leary and I travelled to Canberra and met with Jenny Williams, (Director, Schedule Production and Review Section, Medical Benefits Division) and two departmental staff members. All in all they demonstrated an enormous lack of good-faith bargaining, given that they had been in receipt of the submission for 18 months.

It appears that the need for a consultation item for complex patients for whom ICU admission is deemed not appropriate or necessary is accepted, although there would be no movement on this until 2012. They accepted the

new definition of ICUs, although I pointed out that the work to draft this had been done at the Department's request. Ironically, having taken 18 months to reject the bulk of our submission, we were told that it would take only four weeks to gather the views of other stakeholders (ACCCN, AHIA, APHA etc.) with respect to the ICU definition.

Our fundamental argument about workforce was accepted, that is, if ICU rebates lag behind other craft groups we will struggle to recruit local graduates to train in ICU and there will be a significant shortage of ICU specialists in the future. However, DoHA is awaiting the release of the KPMG written workforce report.

The outcome of this meeting was disappointing, but not completely unexpected. It is doubly disappointing considering the enormous amount of intellectual effort and capital invested by both Dr Yahya Shehabi and Associate Professor Michael O'Leary.

## MBS Quality Framework

As alluded to above, DoHA has embarked on a process of reviewing the evidence for the clinical efficacy and effectiveness of existing item numbers and applying this methodology to any new procedures or techniques. The first existing procedure to undergo this process is pulmonary artery catheterisation.

A little like the workforce review being performed by KPMG, after initial consultation there appears to be very little progress. The dollar value of PAC to intensivists is small and shrinking, but it will be fascinating to watch how long this process takes and what consensus will be achieved with cardiologists, anaesthetists, intensivists and maybe cardiothoracic surgeons in the room.

Of much greater concern is that this process is applied to items that are much larger in volume and quite difficult to explain on outcome grounds such as invasive pressure monitoring. PricE Committee will attempt to remain apprised of the work of this group and try to ensure that the ICU community is protected from harmful change.

## Workforce

Dr Yahya Shehabi represents ANZICS on the KPMG-convened National Health Workforce Taskforce, now renamed Medical Workforce Australia. He attended one meeting, but there has been no further correspondence or information forthcoming.

At the same time as this body of work is being performed CICM are also surveying Fellows about workforce. While we were assured that ANZICS would be involved in this process we have yet to be invited to any joint meetings.



## Informed Financial Consent

ANZICS was approached by the Office of the Health & Community Services Complaints Commissioner in South Australia after they had received more than one complaint from patients regarding the gaps charged by a practitioner or group of practitioners in South Australia. The PricE Committee provided a written response to a number of questions and provided a copy of our IFC policy.

## Future Directions for PricE Committee

With respect to rebates, it is clear that DoHA is being required to perform in a very tight fiscal environment. We will not achieve a substantive increase in CMBS rebates in the near or medium term. Instead our attention should be turned to one other potential ally – the Health Funds, who may be persuaded to increase gap cover payments to avoid a blow-out in gap charges to their members. The PricE Committee will

commence this avenue of endeavour immediately, starting with the Australian Health Service Alliance that is the overarching body assisting 27 or so funds with administration, schedule setting etc.

Another future development raised by DoHA when we met was that of tele-ICU. This has its own implications with respect to workforce planning. There is significant federal interest and potentially funding to promote this branch of healthcare.

We have concentrated on Medicare rebates negotiation for quite some time. In the public sector we have been almost completely silent; and yet, the pay, conditions and workload in the public sector varies tremendously across our two countries and even between states in Australia. In most states intensivists are paid like any other specialist, but this is significantly different between states. However, I would argue that our work is much more similar between states than between us and other

craft groups. Perhaps our Regional Committees need to be assisting their members with negotiations brokered by AMA, NZMA, ASMOF or whoever their industrial negotiator is.

The PricE Committee is also preparing some web pages for the ANZICS website on ICU information for the public and IFC.

I would like to thank Michael O'Leary for all his hard work and skill in filling the role of PricE Committee Chair over the last 12 months or so, and also to thank Yahya Shehabi, who filled the position for six years prior to that. I have made it abundantly clear to the Committee, that, having been a member of the PricE Committee since 2004, I most definitely intend remaining as Chair for 12-18 months as a maximum. We have significant talent, skill and experience on the committee so I'm sure a suitable successor will be nominated in due course.

**Ian Jenkins**  
**Chair, Price**



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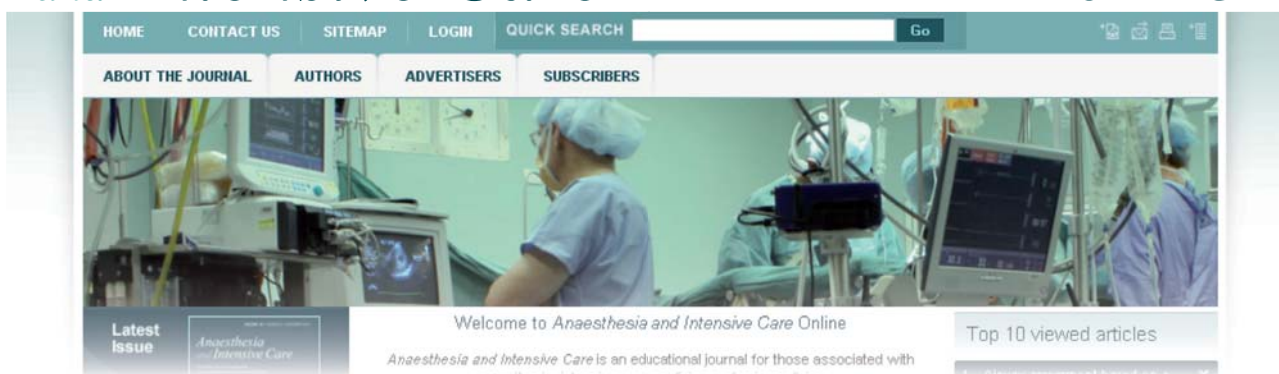


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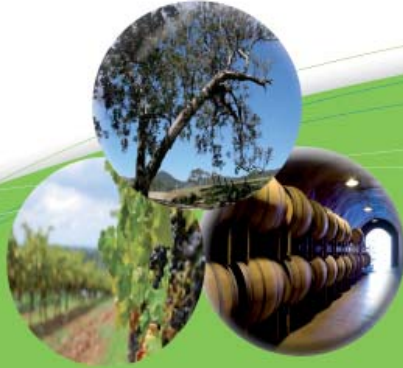
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