

The Intensivist

The Christchurch Earthquakes: Life on Unsteady Ground

The assassination of John F. Kennedy on November 22nd 1963 was one of those shocking, poignant 'where were you when' moments that create collective memories of historic events. For the 380,000 residents of Christchurch their JFK moment was Tuesday 22nd February 2011 at 12.51pm, when a 6.3 magnitude earthquake devastated large parts of the city and cost 181 lives.

To the casual observer a magnitude 6.3 earthquake may seem relatively small. Indeed, a 7.1 earthquake had struck the region some five months earlier and caused significant inconvenience but ultimately no loss of life. What made the February earthquake so destructive was a combination of four factors. The first of these factors revolved around the epicentre; in September the earthquake originated some forty kilometres west of Christchurch and at a depth of ten kilometres. In contrast, February's epicentre was centred within the suburbs of the city itself (less than ten kilometres from the city centre) and only five kilometres below the surface. This immediate proximity limited the dissipation of seismic energy that geographic distance normally allows. The second factor regards the seismic descriptive term 'magnitude'



Pyne Gould Building after Christchurch earthquake

or Moment Magnitude Scale (to give it its full term). Magnitude (M) describes the energy released by the earthquake and does not reflect wholly its destructive nature. One of the key factors resulting in catastrophic building collapse is peak ground acceleration (PGA). The PGA metric is used by structural engineers to design and regulate building in earthquake prone regions. The PGA in February was 2.2 g (the acceleration due to Earth's gravity, equivalent to g-force)

compared to 1.26 g in September and is among the strongest ever recorded in history. This PGA is beyond any current building codes. The third factor was one of timing; the first earthquake struck at 4:35am when the city was quiet and most kiwis were in bed. Unfortunately the February earthquake struck at lunchtime and in late summer. As a consequence, the city centre was bustling with business people, shoppers and tourists. The vast majority of deaths occurred in

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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

and around buildings that would normally be deserted in the middle of the night. The final factor was related to the subtle damage and resulting structural weakness suffered by many buildings in September. The laborious process of checking the tens of thousands of buildings damaged in the Canterbury region was well underway, but far from complete when the February earthquake struck. Whether the catastrophic failure of the Pyne Gould and CTV buildings was a consequence of previous damage will be the substance of enquiries in years to come.

By mid-February 2011 Christchurch hospital staff were well versed in the sport of magnitude guesstimation. Their skills were honed by the hundreds of aftershocks that had gently shaken the hospital with decreasing force and frequency since September 2010. However, at 12:51pm on 22nd February the building shook violently for about 15 seconds. This was followed by further violent aftershocks at 13:04 (5.8M), 14:50 (5.9 M) and 14:51 (5.1 M). Between these powerful shakes the ground continued to move, creating a sensation similar to that of being at sea. The hospital was designed in an era when the benefits of natural light were not

appreciated and despite the time of day much of our windowless building was plunged into complete darkness. The first hospital backup generator failed, suffering severe damage inflicted by the acceleration forces it had not been designed to withstand. The second generator limped along, intermittently supplying variable parts of the hospital. The darker corners of the ICU were illuminated purely by the LED screens of the ventilators functioning on their internal batteries. Christchurch ICU is a 15 bedded unit and at the time there were 14 patients (eight ventilated) in the department. All monitoring was lost due to power failure, but an ongoing medical gas supply and internal ventilator batteries allowed us to practice basic critical care. Clinical assessment of hypoxaemia and pulse palpation replaced our normally sophisticated electronic patient monitoring. A dusty cupboard revealed the one remaining sphygmomanometer and this was passed between the more critically unwell patients.

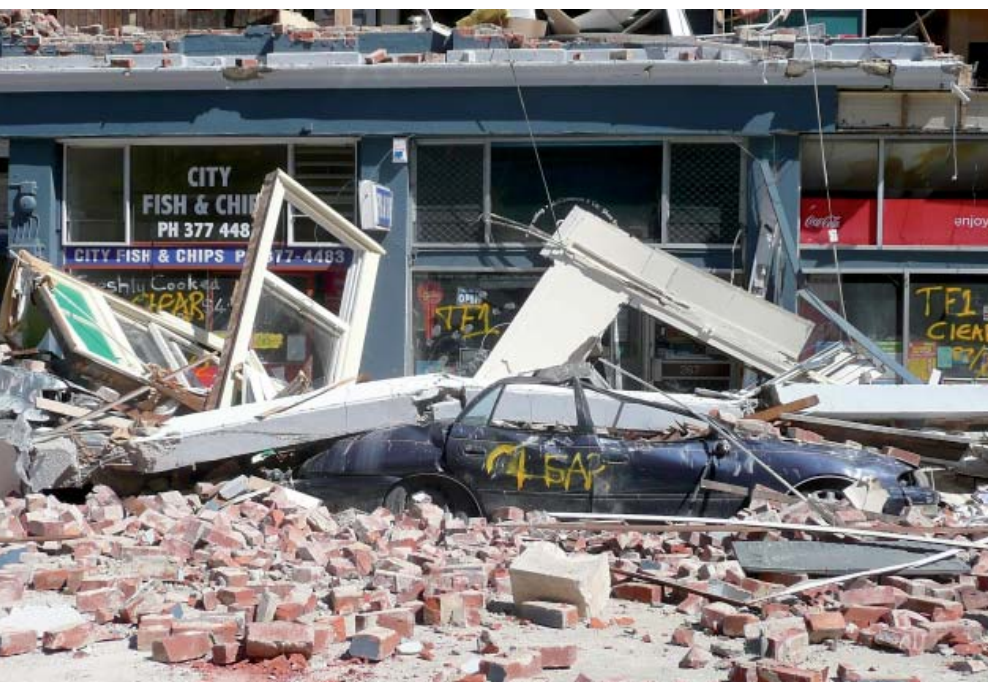
The ICU is situated on the floor above the emergency department and this provided an excellent vantage point to observe the first dusty patients arriving on homemade stretchers, in ambulances, police cars, private

vehicles and even strapped to car roofs. The flawed logic of having the key services of theatres, radiology and the ICU on the first floor was soon apparent. In the absence of working lifts, the access to this floor is provided by three stairwells, all of which have stairs that are 130mm wide and are accessed by doors 85mm in width. Access to our service was clearly going to be a challenge.

Whilst the timing of the earthquake was poor for the central city, it was excellent for the hospital. The time of day meant that the emergency department was soon well supplied with eager medical and nursing staff from all disciplines. The absence of any telecommunications meant that no one had any idea about the gravity of the situation or indeed the safety of their own families. Information was gleaned from eye-witness accounts from casualties and the arriving off duty staff. The emergency department saw 365 patients in that first 24 hours and admitted 171 patients. The lack of CT imaging meant that clinical skills, point-of-care testing, plain radiology and ultrasound were the limited modalities available to diagnose the complex, unfamiliar pattern of injuries that were soon presenting.

In preparation for an influx of multiply injured earthquake patients, a rapid triage of the incumbent ICU population was undertaken. Five patients were moved to either a lower acuity area or theatre recovery. The ICU received its first patient, via stairs, at 13:55 and this was followed by another 15 over the next 24 hours (14 directly earthquake related).

The support from the New Zealand critical care community was outstanding, with offers of retrieval, staff and equipment from throughout the country. Over the next 48 hours 14 patients (eight earthquake and six non-earthquake related) were transferred to intensive care units in Auckland, Waikato, Hawkes Bay and Wellington. This help was delivered in a rapid, professional and selfless manner by civilian medical personnel who had no need to be in such a potentially volatile disaster zone and their acts



Aftermath of the Christchurch earthquake

(as well as food parcels) were greatly appreciated. This national assistance allowed us to swiftly reduce the load on our services in anticipation of the expected influx of crush injury victims from around the city. Unfortunately, this influx was not realised and the last true acute earthquake ICU admission was at 02:30am on 23rd of February, less than 14 hours after the earthquake. There were no further heroic rescues, or miracles pulled from the rubble, just an ever increasing list of casualties confirmed dead.

The types of patients admitted to the ICU were primarily the victims of fallen masonry or entrapment. Our management of rhabdomyolysis was quickly honed and the benefits of amputation over limb preservation were realised in several patients.

The following day a national state of emergency was declared and this was illustrated by the presence of tanks, armoured personnel carriers and multiple military staff throughout the city. Travelling to hospital required lengthy detours and passage through military checkpoints. However, arrival at work provided many staff with much needed respite. Ready access to supportive colleagues, clean water, power and the luxury of flushing toilets was a far cry from what we all had to go home to.

For the world outside Christchurch, this is where the story ended. A devastating 9.0 M earthquake in Japan a few weeks later meant that the world's media and many of the remaining multinational urban search and rescue (USAR) teams were rightfully redeployed to an almost incomprehensible disaster almost 10,000 kilometres away. However, for the population of our city, February 22nd was only the first chapter in a very long book. Over the next few days much of the city slowly regained power, the USAR mission was changed from rescue to recovery after nine days, the national state of emergency ended after five weeks, water was declared safe to drink after six weeks and the final victims were officially identified by the Coroner three months later.



Army Tanks stationed outside Christchurch Hospital as the government declares a national state of emergency

The true impact on the city is yet to be realised. Reconstruction of the city is likely to eat up about 7.5 per cent of 2011 New Zealand GDP and this national economic burden is one of the largest that any modern economy has ever previously faced following a natural disaster. The current reconstruction cost has been estimated at \$15 billion and is likely to take several years if not decades.

The impact on the hospital has been significant. Three 25-bedded wards were immediately and permanently closed by the events of that day. This equates to approximately 15% of the hospital acute beds. This has resulted in significant changes in acute healthcare delivery in the city. The biggest impact of the day was upon staff. Concerns about mass loss of healthcare staff are as yet unrealised. This may change as the economic ties inflicted by mortgages on (now) worthless homes, are loosened with state purchase offers on some 5000 homes in the worst affected areas of the city. This is just the start as the fate of a further 35,000 homes is yet to be decided. The biggest challenge faced by our staff is their desire to rebuild the city conflicted with their ability to leave this shaky city.

The multiple aftershocks and the uncertainty they bring is the most distressing part about current life

in Christchurch. Since September 2010 there have been thousands of aftershocks in Christchurch but most of these are barely perceptible. To put aftershocks in context we propose this subjective scale; anything greater than a 4 M will wake you from sleep, a 5 M will stop you from doing whatever you are doing and greater than a 6 M causes buildings to fall down (the scale is logarithmic). As of the 3rd July there have been 296 x 4 M aftershocks (just under one per day), 27 x 5 M and three over 6 M, the last of which was on 13th June 2011.

The future is not all doom and gloom for Christchurch. The number of people leaving the city is far less than many had feared. In a few years time Christchurch will be a modern, exciting, well designed and economically affluent (thanks to a healthy construction sector) city. It will also be blessed with a large reclaimed greenbelt along the banks of the Avon River, stretching from the city to surf. That sounds like *the* place to be and it is where many of us plan to commit our future.

Laura Khodaverdi
ICU Registrar
Christchurch Hospital

David Knight
ICU Consultant
New Zealand ANZICS Secretary

From the President's Desk



I am pleased to be able to bring you news of good progress on a number of initiatives that we have been pursuing over the last year.

Education Committee

The Education Committee met at Melbourne Airport in May and I think all present would agree that it was a useful and productive first meeting. Thanks must go to Gerry O'Callaghan, who stepped forward to take the position of Chair. Reading the draft minutes, one would be struck with a degree of trepidation at the vast list of tasks the Committee believes it must address. One or two are seen as priorities, but of course it will be up to Gerry to guide the Committee in the direction he feels may be most productive.

Much of the meeting was spent discussing the ASM and initiatives that might increase the conference's attractiveness to medical delegates. It was suggested that the Education Committee endeavour to provide a structure and templates for the ASM organising committees to ensure that corporate knowledge is maintained from year-to-year. The Committee will also advise ASM organising committees on potential overseas invited speakers (to prevent repetition of 'frequent flyers'), and advise on the scientific program and themes. It was suggested that ANZICS Committees be encouraged to run sessions annually at the ASM, both to increase interest in the respective Committees' activities but also to reduce the need for additional meetings to be organised during the year, as it is clear the meetings calendar is getting very congested.

The Education Committee is now an important resource for all members involved in organising educational activities and I'd encourage those of

you in this category to get in touch with the Committee to see how it can assist you. It is important to note, however, that there is no intention for the Education Committee to take over the running of meetings or try to take ownership of events away from organising committees, and this also applies to the ASM. We fully recognise the hard work and dedication of organising committees and hope that this new resource will make their work easier.

The Education Committee hopes to work closely with CICM, especially once the new CPD program is launched, in order to ensure that ANZICS educational activities fit in with the CPD requirements for members.

Before I leave the topic of education and meetings I would just like to mention a couple of other related matters. Our combined meeting with the Singapore Society of Critical Care Medicine in Singapore at Easter was a great success. The program was of very high quality; I personally really enjoyed all the sessions I attended, and feedback from delegates was very positive. Total registrations hit 615, well in excess of our target of 400. Ninety-five were from Australia and New Zealand and the meeting resulted in a healthy profit that will be shared between the two societies. I would like to thank Ian Jenkins from ANZICS and Loo Shi from Singapore for their enthusiasm and courage to push us forward with this initiative – all involved, I think, found it a really rewarding experience and there is already a commitment between the two societies to repeat the meeting in 2013.

We were approached by the Melbourne Convention and Visitor's Bureau to consider bidding for the 2017 Congress of the World Federation of Societies of Intensive and Critical Care Medicine. The Bureau has considerable resources available to it to assist

with the bid and the running of the meeting. Many of us will fondly remember the successful meeting in Sydney in 2001, so with much enthusiasm Stephen Warrillow and Bill Silvester, along with Gabby Hanlon representing the ACCCN, have taken on the task to investigate the possibility of ANZICS/ACCCN submitting a successful bid. At this stage we have only expressed an interest in bidding – the actual bid is presented to the WFSICCM Council in Columbia in November. Obviously there will need to be a significant degree of due diligence undertaken by ANZICS and the ACCCN before we can actually present a bid, with the ASM being of such importance to the finances of both organisations, so at this stage just watch this space.

Deepak Bhonagiri has been negotiating on behalf of ANZICS with an Indian group that is keen to organise a travelling ANZICS-led education road show annually in India. We now have an agreed contract between ANZICS and the Indian organisers. It is envisaged the event will occur each November and ANZICS needs to provide the speakers – we would be looking for people who had presented at recent ASMs or similar major meetings. If anyone is interested in being considered to take part in this initiative please contact the ANZICS House staff in Melbourne to leave your details.

Rural & Regional Affairs

For many years it has been clear that the Conjoint Rural Committee that is formed jointly with CICM and its predecessor(s) has been struggling to gain traction. The reasons for this are multiple, but finally led to the resignation of the Joint Chairs late last year. Both ANZICS and CICM believe strongly that rural and regional affairs are of high importance and we are committed to giving a voice to members and fellows from rural and regional locations.

The future of the Committee was discussed at the respective Board meetings in February and I have continued to speak with John Myburgh about this matter over the intervening weeks.

I think one of the main problems that the Committee has faced has been a view that the parent organisations needed to set the agenda for the Committee. Rather than this 'top down' approach, I feel that the issues need to be raised and developed by rural and regional practitioners themselves. ANZICS has therefore decided as a first move to form a Special Interest Group, initially as an e-mail list, for rural and regional affairs. I hope that most of you who have a membership address in a non-metropolitan location will have already been contacted and enrolled into this group. We would also like to offer membership of the group to those with metropolitan addresses that nonetheless have a principally rural/regional practice. I have also heard from some members that consider they might have been missed from the non-metropolitan list, so please do get in touch with the membership team at ANZICS House if you would like to join the SIG. I also propose to contact ANZCA and ACEM to ask if they can contact their rural/regional fellows and invite those that have a significant commitment to intensive care work to join the SIG.

Forming the SIG is, of course, only the first step and we still need to work out how we facilitate the development of issues from the grass roots upwards. I know that Mike Anderson, CICM Rural Affairs Officer, has some ideas on this and I will be discussing the matter further at the forthcoming CICM Board meeting. If anyone would like to become more involved in this area please do get in touch.

Developments at CORE

The negotiations regarding the potential relocation of CORE to Monash University have taken longer than I had anticipated. This has been principally because there are a number of different models under

which CORE could be located at Monash and it has been difficult to evaluate the benefits and risks of each and, of course, it has been vital to ensure that we are making a decision in the presence of all available information. I am pleased to say that the CORE Management Committee presented a formal proposal to the ANZICS Board last month and the ANZICS Executive is currently evaluating the potential impacts of the proposal on the Society as a whole. I anticipate the Board will be in a position to make a final decision on this matter in a few weeks time.

Relationship with CICM

ANZICS continues to enjoy a very close working relationship with CICM. As I have previously indicated, we have been actively investigating various options where we might be able to share resources with CICM and thus potentially reduce duplication and overheads for both organisations. Principle among these was the potential for relocation to shared premises with CICM. As I explained in the last edition of *The Intensivist*, as we were unable to move to a position where we could contemplate relocation in the short term, we had to decline the opportunity to take a tenancy in the floor above CICM in their Greville Street building. Recently we decided that the vacant space available within the CICM-leased floor space was insufficient to permit relocation of the Society offices (even if CORE were to relocate to Monash). It seems therefore that there are no realistic options to share resources at present and I have taken the issue off of the Board agenda pending a change in either ANZICS or CICM plans regarding their office accommodation.

Workforce Planning

We were contacted by Health Workforce Australia to advise us that the PricewaterhouseCoopers-led study into the intensive care workforce had been finalised but

no report had been produced. This was somewhat surprising news as Ian Jenkins and I were told when we visited DoHA in Canberra in January that the report was complete and we would be receiving a copy for our comments prior to the report being presented to government.

It would appear that we are not going to get any information from the government regarding ICU workforce and if we want this information we will have to source it ourselves. ANZICS has been provided with a copy of the results of the recent CICM workforce questionnaire, however, while we agree that the findings are very interesting and worthy of further study and publication, we are not sure that they particularly advance workforce planning. Part of the problem is that it is not really clear how to conduct an effective workforce planning exercise. Nonetheless, we still believe the matter is vitally important and ANZICS has a duty to try to come up with some information regarding likely requirements for intensivists in Australia and New Zealand. As a first step the PricE Committee will formulate the workforce questions that need to be addressed and analysed using CORE data.

South Australian Coronial Report

Many of you will be aware of the findings and recommendations of the South Australian Coroner following an Inquest into the death in intensive care of a patient after cardiac surgery. ANZICS has received a number of representations from members expressing their disquiet over the conduct of the Inquest and the subsequent findings and recommendations and I'd like to thank those members who have taken their time to contact the Society on this matter. The matter is complicated and any response would need to be prepared only following very careful consideration. A significant period for discussion was allowed at the Board meeting and it was clear from this that the level of concern is very high and that

there is a general view that the Society should take some position on the matter. It has been decided, therefore, that an editorial will be written and published in *Anaesthesia & Intensive Care* and *The Intensivist*, which will hopefully serve as a resource for members who may find their practice being questioned in light of the Coronial report. We will be liaising closely with CICM regarding this and it is possible that the final document may be jointly authored.

The Intensive Care Foundation

Finally, I want to again emphasise the need for us all to do as much as we can to promote the Intensive Care Foundation. The ICF took a significant hit during the global financial crisis and is struggling to reposition itself among the plethora of charities now fighting for the donor dollar. Yahya Shehabi and the ICF Board (of which I am now a member) have developed a comprehensive new strategy for

fundraising, but it suffices to say that it is unlikely to be successful unless there is also widespread buy-in from the intensive care community. The ICF is your Foundation and the money raised is a vital part of ensuring that Australian and New Zealand intensive care continues to perform at the highest level worldwide in terms of research and quality of care.

Michael O'Leary
ANZICS President

Regional Reports

New South Wales

NSW ANZICS has been steadily progressing over the last few months. We have conducted one CME sessions since the last report, which was well attended. A hands-on training session on pacemakers and intra-aortic balloon pump management and trouble shooting in the ICU was conducted at St Vincent's Hospital. Approximately 20 trainees were able to participate, with many more expressing an interest to attend. This was followed by a case discussion highlighting the role of echocardiography in the ICU. 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 are aware ANZICS conducts a wide variety of activities for intensivists and intensive care, please don't hesitate to contact me or one of the Committee members below if you wish 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,
Michael O'Leary

CTG: Ian Seppelt, David Gattas

Safety & Quality Committee:
Tony Burrell (Chair)

Death & Organ Donation Committee:
Deepak Bhonagiri

Deepak Bhonagiri
New South Wales Chair

Queensland



July 2011! Where has the year gone? It's incredible to think back to the distant floods and cyclones of the summer, as we find ourselves in the grips of

another winter. Queensland remains very active on the critical care front. The conference committee has been incredibly busy finalising arrangements for the 2011 ANZICS/ACCCN Intensive Care Annual Scientific Meeting, which will be held in Brisbane from 13th – 15th October at the Brisbane Convention and Exhibition Centre. The theme for this year's meeting – 'Tools of the Trade: Tips, Tricks and Technology'- offers an exciting program with presentations from world leaders sure to be informative and thought provoking.

The Noosa Clinical Trials Group meeting was a great success, with exciting research presented, including

the findings of DECRA, STATinS and PROTECT. Yet again, Australasia is centre stage in contributing to the body of intensive care literature, with the results of these landmark studies now finding their way into the daily practice of critical care specialists. While ongoing studies, such as ESCAPE, offer promise of further vital information for best practice.

The Queensland Intensive Care Training Pathway (ICUTP), arguably a flagship in intensive care training, continues to evolve under the guidance of its medical advisor Dr Bruce Lister. This is a statewide initiative designed to promote and advance the training and educational needs of intensive care vocational trainees. The pathway assists accredited intensive care units to deliver ICU training in Queensland that is high quality, sustainable and congruent with College of Intensive Care Medicine (CICM) training requirements. Specifically, it aims to maintain an ICU workforce to meet clinical service needs, while maximising statewide ICU training capacity through facilitated placement of trainees. Education of trainees is central to this process and establishing improved access to education in regional centers by way of podcasts and webcasts is critical to the mission. Encouraging our trainees to venture into regional centers where they have the opportunity to add an entirely different, yet highly complementary, component to

their training is a worthwhile objective. This model may also ultimately see an increased number of intensivists wanting to commit to working in rewarding and challenging regional practice.

With increasing numbers of trainees entering the workforce we are likely to see greater numbers of specialists working in regional areas. Until this is a reality, Queensland will remain a leader in the delivery of clinical support by telemedicine. The Royal Brisbane and Women's Hospital has been using this technology to support regional centers such as Bundaberg Hospital and Hervey Bay Hospital for a couple of years. Very gratifying has been the marked improvement in standardised mortality rates in these centers following the introduction of telemedicine.

We are delighted to be involved in the establishment of a quarterly educational evening which is ANZICS branded and supported by industry. Dr Peter Kruger shrewdly noted that we are blessed to have a wealth of talented intensivists who often present at far flung meetings, but because of work commitments many local folk miss out on their pearls. This meeting will provide an opportunity to showcase this work locally. The first session was held on the evening of Wednesday 22nd June and we were very fortunate to have Associate Professor Michael Reade visit from Victoria to present on issues related to sedation.

We in Queensland look forward to welcoming you to our state for an exciting meeting in October. See you there!

Anthony Holley
Queensland Chair

South Australia



Four months have passed down in sleepy hollow since my last missive. As predicted the AGM came and went peacefully in conjunction

with the CICM AGM and the Tub Worthley Scholarship meeting was held on 16th May. The latter produced six presentations of registrar work, all interesting, and culminated in a win by John Raj from the QEH for 'Does waist circumference predict mortality in Intensive Care patients?' (Hint – the answer isn't hard to guess). It was an enjoyable evening both educationally and socially and I must say how much Tub's continued involvement with this meeting is appreciated. He puts an enormous effort into critiquing the presentations and I wish I knew the secret to his boundless energy.

The other thing which has occupied those in SA recently has been the release of the Coroner's findings in the Inquest into the death of Vera Allen. Although at the recent ANZICS Board meeting there was some criticism of SA for thinking it's the centre of the universe (what – you mean it isn't? Wait till I see that Galileo chap), it may have potential repercussions beyond the SA borders and I suspect most of you will have already heard about it. I don't want to go over the medical or legal arguments here; others of greater expertise will undoubtedly do so better than I can. But the extensive discussion of this at the Board meeting set me thinking about the whole process. It was clear that the majority of medicos disagreed with the Coroner's findings in some degree, often very strongly. The question was then what to do about it? The first option seemed to be to do nothing and just wait for it all to blow over. Of course, this could be seen as tacit acceptance of the findings, which may then be taken as precedent in other actions; so this didn't appeal. The second option, which was eventually chosen, was to ask someone not directly involved (i.e. not from SA) to write a document outlining our concerns as a professional group, and have it published (for example, in *The Intensivist*) to place it on public record. This could then be referred to, if necessary, in future cases. The third, and most interesting option, was to challenge the Coroner's findings directly, which would require an appeal to the Supreme Court. The Court could choose to reopen the Inquest, rehear all the evidence, and hear further evidence as it saw fit. All the involved parties would

need legal representation, as would ANZICS in bringing the challenge. Given the duration of the original Inquest, it's not hard to imagine that any further action would take weeks or months. Work out that many hours, multiply it by the charge-out rate of QCs, and you're not going to get change from a million; maybe not even from five. If ANZICS were to succeed and the Coroner's findings were overturned, they still would be likely to have to fund their own costs; should they lose (and even if you believe that the Coroner was in error, there's no guarantee a court would agree) you may have to pay for the lot. That could result in a bill for \$10,000 or more for every ANZICS member – and I doubt many members would accept that, even if they do believe SA is the centre of the universe. So again we come back to the old chestnut – justice and the law are different things; and you get the justice you can pay for. I don't have any solution, but I can't help feeling there's something wrong somewhere with our system. Please discuss among yourselves.

David Durham
South Australian Chair

Victoria



Victorian intensive care units remain extremely busy, with demand for time-critical high level services remaining high. Media interest

has been piqued by increasing numbers of critically ill patients needing inter-hospital transfers when the institution at which they present cannot accommodate them within the ICU. ANZICS data demonstrating the relative shortage of ICU beds within the state has been quoted extensively and provides objective criteria to support the many anecdotes of challenges in dealing with the current major resource limitations.

Much activity in Victoria remains focussed on coordinating education. A themed review evening is planned for November, which all Victorian

members will be invited to attend in due course. Similar recent meetings have proven quite popular and a good turnout is once again anticipated.

Also of note is a plan for Melbourne to bid for the WFSICCM Congress for 2017. These major critical care meetings are held every four years and provide a remarkable forum for the advancement of intensive care practice at a global level. Given the incredible success of the 2001 Sydney Congress, which was the last occasion that ANZICS hosted, it is likely that our attempt to bring the Congress will be viewed very favourably. A local bid committee has been convened and the steps necessary to build a successful bid submission have commenced.

Stephen Warrillow
Victorian Chair

New Zealand



A very enjoyable and educational New Zealand regional ANZICS conference was recently held at Taupo. The presentations about advanced care planning were particularly inspiring and interesting. Next year's conference is scheduled to be held at Waikato. A one-day meeting to analyse the lessons learnt from the Christchurch earthquake is also planned for the near future.

There was an excellent New Zealand pass rate in the recent CICM Part 2 exam and congratulations go to all those who sat the exam.

Alex Psirides has agreed to be the New Zealand representative on the new ANZICS Education Committee. The intention of the new Committee is to provide more structure to the various teaching activities that ANZICS supports.

The NZ ICU registrars meeting will be held at Waikato this year; Wellington is also likely to hold a separate CICM exam preparation course.

Janet Liang
New Zealand Chair

General Manager's Report



Welcome

We have recently welcomed two new members to the ANZICS team, Joanna Craven and Jennifer Holmes.

Joanna has taken on the role of Project Officer – CORE Registries and Jennifer has been appointed as the Executive Officer – Safety & Quality Committee.

Annual General Meeting

The 2011 Annual General Meeting will be held at 5.30pm on Friday 14th October, 2011 at the Brisbane Convention and Exhibition Centre.

Call for Nominations – ANZICS Executive

A call for nominations for positions on the ANZICS Executive will be circulated to the membership via email at the end of the month. All financial full members of the Society are eligible to stand for election. Nominations must be signed by two full members of the Society and the Consent to Act signed by the nominee. Elections will be held at the ANZICS Annual General Meeting on

Friday 14th October, 2011 at 5.30pm at the Brisbane Convention and Exhibition Centre.

Are you up to date?

A reminder to update your contact details to ensure that you receive all ANZICS communications. Contact Nathan Etinger nathan.etinge@anzics.com.au or +61 (3) 9340 3400.

Conferences and Events

Registrations are now open for the 5th International Conference on Safety, Quality, Audit and Outcomes in intensive Care (SQAO 2011) and the Clinical Trials Group Winter Research Forum, in the Hunter Valley, NSW from 1st- 5th August. Programs for both meetings are available on the meeting websites and I encourage you all to attend. For further information or to register visit www.sqao2011.com and www.anzicsctg.org

The ANZICS/ACCCN Intensive Care Annual Scientific Meeting (ASM) 2011 will be held at the Brisbane Convention and Exhibition Centre from 13th-15th October. A preliminary program is available to download from the website, visit www.intensivecareasm.com to register today.

Erin O'Sullivan
General Manager

Conferences and Events

Registrations are now open for the following:

5th International Conference on Safety Quality Audit and Outcomes (SQAO) 2011

1-3 August, 2011
Crowne Plaza, Hunter Valley, NSW
www.sqao2011.com

CTG Winter Research Forum

4-5 August, 2011
Crowne Plaza, Hunter Valley, NSW
www.anzicsctg.org

ANZICS/ACCCN Annual Scientific Meeting 2011

13-15 October, 2011
Brisbane Convention and Exhibition Centre, Brisbane, QLD
www.intensivecareasm.com

Membership Report



Membership of the Society continues to grow. There has been a significant increase in membership

applications over the past few months due to the efforts of all ANZICS members, who have been encouraging their colleagues to join the Society. There has never been a better time to join ANZICS with upcoming events such as the ANZICS/ACCCN ASM in October and the Safety, Quality, Audit and Outcomes Conference in August, as well as the formation of new committees and interest groups.

ANZICS is a society dedicated to its members and it relies heavily on its members to survive. Staff at ANZICS House recently sent out annual renewal forms for 2011/2012.

I encourage all of our members who are yet to renew their membership to do so. Please contact Nathan Etinger (anzics@anzics.com.au) or +61 3 9340 3400 with any queries or feedback.

Finally, I would like to personally extend a warm welcome to all our new members, as listed below.

Dr David Tripp
Hutt Valley DHB

Dr Kieron Gorman
The Royal Melbourne Hospital

Dr Satnam Solanki
Princess Alexandra Hospital

Dr Gordon Laurie
Princess Alexandra Hospital

Dr Mathew Brain
The Alfred

Dr Kannan Ramanathan
Launceston General Hospital

Dr Sheila Hart
Austin Health

Dr Naomi Diel
Nepean Hospital

Dr Paul Grolman
Joondalup Private Hospital

Dr Sidharth Agarwal
Royal Darwin Hospital

Dr John Raj
Royal Adelaide Hospital

Dr Rajendra Goud
Royal Adelaide Hospital

Dr Theresia Van Beek
Royal Adelaide Hospital

Dr Mark Plummer
Royal Adelaide Hospital

Dr Sumesh Arora
Prince of Wales Hospital

Dr Kollengode Ramanathan
Royal Brisbane Hospital

Dr Lesley Maher
Capital and Coast
District Health Board

Dr Melanie Saw
Fremantle Hospital

Dr Ravikiran Sonawane
Ipswich General Hospital

Dr Ito Asako
St. George Hospital

Dr Kim Grayson
Royal Melbourne Hospital

Dr Michael Park
Hawkes Bay Hospital

Dr Richard Chalwin
Lyell McEwin Hospital

Dr Mohammad Ariful Huq
Bundaberg Base Hospital

Dr Edda Jessen
Middlemore Hospital

Dr Shailesh Bihari
Flinders Medical Centre

Dr Nikki Yeo
Royal Adelaide Hospital

Dr Peter Thomas
Lyell McEwin Hospital

Dr Sunil Gupta
Auburn Hospital

Dr Ben Gelbart
Geelong Hospital

Dr Daniel Seller
St Vincent's Hospital

Dr David Brewster
The Alfred Hospital

Dr Alex Kazemi
Auckland City Hospital

Dr Kevin Plumptre
Royal Children's Hospital

Andrew Turner
Honorary Secretary

Clinical Trials Group (CTG) Report



The past four months have been a busy and productive time for the CTG. There are 16 CTG endorsed studies currently

in set-up, open to recruitment, or in active follow-up. The CTG Executive

continues to process a steady stream of applications for endorsement of new studies and manuscripts arising from CTG research. We are now one year into the current three-year strategic plan and a large majority of the key activities that were set out for this time point have been achieved or are in process. This represents hundreds of hours of voluntary time from members

of the CTG Executive and all of the many other fantastic individuals who are active contributors to CTG research and activities.

Two landmark studies published in the NEJM

The DECRA study was simultaneously presented at the ISICEM meeting in Brussels and published online in the



New England Journal of Medicine on 25th March. The study demonstrated that early decompressive craniectomy for severe diffuse traumatic brain injury reduces intracranial pressure and length of ICU stay but, contrary to expectations, resulted in more patients with unfavourable long-term neurological outcomes. The intervention had been largely adopted as standard of care and the trial will result in improved outcomes for patients with severe diffuse traumatic brain injury and substantial cost savings to the community. The trial is an outstanding achievement and I offer my congratulations to Jamie Cooper, Lynn Murray, Jeff Rosenfeld, and the DECRA investigators who have dedicated themselves over many years to see the trial completed. The PROTECT study was also simultaneously presented at ISICEM and published online in the New England Journal of Medicine in March. This trial showed that low molecular weight heparin was not superior to unfractionated heparin in decreasing the incidence of proximal deep-vein thrombosis although there was a reduction in pulmonary embolism with low molecular weight heparin. The study was a collaboration between the Canadian Critical Care Trials Group and the ANZICS CTG. Congratulations also to all of the PROTECT investigators. We now

eagerly await the publication of the STATinS and ENTERIC study results – both are expected to be submitted in the near future.

Funding announcement

The HEAT study, which will compare paracetamol to placebo for the management of fever in critically ill patients with sepsis, has received \$1.2 million over 3 years from the New Zealand Health Research Council. This is the maximum amount awarded by the HRC and exceeds the total of all funding previously awarded to intensive care research by the Council. It is also the first time that a CTG endorsed study has received a primary grant from a New Zealand funding body. Congratulations to Paul Young and all of the HEAT Investigators.

Mentor Program

In March the CTG launched a formal mentor program for early career investigators. Novice researchers are paired with a Senior CTG investigator with the aim of providing strategic advice on how to enhance personal track record, develop research skills, and identify opportunities for involvement in research activities. I strongly encourage anyone who has a keen interest in developing a research career to consider joining the program by contacting myself, Shay McGuiness, or Rhiannon Tate.

Meetings

Noosa 2011 was a highly successful meeting with confidential first presentation of results from the DECRA, PROTECT and FEAST trials – all subsequently published in the NEJM, as well as the STATinS, TAME and SPICE Observational study results and 16 new study proposals. Our guest speakers Prof Jeffrey Drazen and Prof Kathy Rowan made outstanding contributions to the meeting and there was a palpable feeling of pride and enthusiasm in Noosa this year. The passion, expertise and dedication that exists within the CTG community is truly remarkable.

The CTG held a half-day research foundations workshop in conjunction with the Singapore-ANZICS ASM in April. The aim of the workshop was to support the development of multicentre research in the Asia Pacific region by providing practical advice on establishing a research network and preparing an ICU for conducting research. Feedback from participants was very positive and it is hoped that the CTG can establish a program of workshops to be held throughout the region over the next few years.

The annual CTG Research Development Day was held in June in association with the CICM ASM. The RDD provides an opportunity for early-career investigators to present research proposals for critique and advice from Senior Investigators. I'd like to thank Ian Seppelt for organising the day and extend my congratulations to Adam Deane who was awarded the prize for best presentation for his study proposal to investigate the pathogenesis of critical illness hyperglycaemia (CIH).

The next CTG meeting on our calendar is the Winter Research Forum to be held 4-5 August in the Hunter Valley, immediately following the SQAQO meeting. The pipeline of future CTG studies is certainly comprehensive with ten new study proposals to be presented, discussed and debated at this Forum. As always, I encourage all site investigators and Research Coordinators to attend and contribute to the development of the next generation of CTG studies. Information about the Forum can be found at www.anzicsctg.org

CTG Membership

I would like to thank all of the units who have supported the CTG this year by paying their membership subscription. We have had a fantastic show of support with prompt renewal of memberships and several new units joining this year. This is in large part due to the fantastic work undertaken by Simone Rickerby, CTG Executive Assistant, in managing the CTG membership process.

Steve Webb
CTG Chair

CORE Report



ANZICS CORE is entering a period of development and growth. Changes over the past two years have now

resulted in a settled, experienced and motivated team poised for the next phase of CORE's development, to which we have recently welcomed Jo Craven to manage the Critical Care Resources Registry.

Collaboration with Monash University

In the last edition of *The Intensivist*, Michael O'Leary wrote about CORE's plans to relocate staff and activities to become part of the registries group at Monash University. Potential advantages include access to more extensive and cost effective information technology resources, IT professionals already experienced in working with clinical registries, improved career development opportunities for ANZICS CORE staff, a work environment which includes other similar registry groups and access to statisticians, epidemiologists and intensive care researchers, such as the ANZICS Research Centre already located at Monash University;

all of which will lead to improved services for submitting ICUs, while maintaining the ANZICS identity and retaining control over all data. We are now at a stage where the ANZICS Executive is reviewing more extensive documentation detailing the proposed move, pending a definitive decision. We look forward to being able to tell you more very soon.

Jurisdictional Liaison Bodies

ANZICS CORE now provides regular analyses to jurisdictional liaison bodies in Queensland, New South Wales and Victoria. Although their primary role is to provide appropriate interpretation of ICU outcomes in each region, these groups also facilitate communication between local representatives of the intensive care community and ANZICS and the local department of health and are starting to become a forum for research, with each area pursuing local projects. A similar body has recently formed in South Australia and we hope others will follow soon.

The CLABSI Project

CORE, together with the Australian Commission on Safety and Quality in Health Care and in collaboration with the Clinical Informatics and Data Management Unit at Monash University, is nearing completion of

a monitoring system to collect and report information about central line associated bacteraemia to ICUs and jurisdictional bodies. This will effectively become the fourth registry run by ANZICS CORE, in addition to the Adult Patient Database, the ANZ Paediatric Intensive Care Registry and the Critical Care Resource Registry. It is expected to become operational later this year.

Multi-National ANZICS CORE

It is common knowledge that the ANZICS CORE registries cover Australia and New Zealand, but it is less well known that hospitals from other countries also contribute data. Despite the Hong Kong government having made a decision to submit data to ICNARC in the UK, two Hong Kong hospitals continue to submit data to the ANZICS Adult Patient Database. CORE has recently also been approached by hospitals in Fiji and, with the Board's permission, has decided to investigate the possibility of accepting Fijian data. We welcome expressions of interest from other countries too; working out a new acronym which includes these other jurisdictions may, however, prove too difficult ... perhaps we will just stick with ANZICS CORE.

David Pilcher
CORE Chair

ANZICS CLABSI Prevention Project

This project commenced in March 2010 and its objectives are:

1. Decrease rate of CLABSI in Australian ICUs to <1/1000 line days.
2. Accurately and consistently measure the rate of CLABSI in ICUs throughout Australia, with timely reporting to clinicians and benchmarking capabilities.

Implementation

Progress this year has been slower than predicted, mainly due to delays in establishing the website; implementation will probably start in late July. However, other important work on the national definition and surveillance practises has proceeded ahead of schedule.

CLABSI Definition

The Project Manager has worked with a Commission committee to

establish a national CLABSI definition (see link), with the final draft of the implementation document due to be completed by the end of July. This work is important as all jurisdictions will be requested to use the same surveillance definition, and to undertake CLABSI surveillance in ICUs. We hope this will make it a lot easier for ICUs to undertake the project, as the responsibility for data collection will be shared and it will provide meaningful baseline data.

<http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/National-definition-and-calculation-of-Central-Line-Associated-Blood-Stream-Infection>

National Database

ANZICS CORE has successfully tendered to manage the national database. This will provide access to various reports where ICUs can view their own CLABSI results compared to others across Australia. This will

be the first time ICUs have had access to national comparisons and is particularly relevant to states where reporting has not been reliable, and also for PICUs which have not previously had this benchmarking opportunity.

Insertion & Maintenance Protocols

The CDC issued their latest Guidelines for the Prevention of Intravascular Catheter-Related Infections in April

this year. We hope that our insertion and maintenance recommendations will be consistent with both these and the guidelines issued by the ACSQHC & NHMRC, however, some of the CDC guidelines remain poorly/inappropriately referenced; in this instance we will retain the recommendations by our Expert Group.

Gabrielle Hanlon
Project Manager
Gabrielle.hanlon@anzics.com.au

Death and Organ Donation Committee



The Committee has been active recently, with email correspondence, a meeting via teleconference on 23rd May and a face-to-face meeting of the End-of-Life Care Working Group on 20th May.

The Working Group met under the Chairmanship of Bill Silvester and established the groundwork for revision, or perhaps more correctly, replacement, of the ANZICS document on Withholding and Withdrawing Treatment. With the changes that have occurred in our practice, case-mix, community expectations and innovations, such as organ donation after cardiac death, this document was overdue for review. The Working Group consists of ANZICS members with broad experience in intensive care and expertise in medical ethics and end-of-life issues. The draft document from the Working Group will be circulated widely for consultation and feedback.

Two main issues were considered at the Committee's teleconference. The first of these was the revised ADAPT course, which is currently being rolled out across Australia and New Zealand. The same content should also be available in Hong Kong for members and trainees

working there, so the requirements for the completion of the Fellowship of the College of Intensive Care Medicine can be met locally. The Committee welcomes feedback on the revised course and a more detailed review of its content and delivery will be carried out in approximately mid-2012, by which time the course should have been held in all jurisdictions.

The second issue considered by the Committee at its recent meeting was the section in the ANZICS Statement relating to determination of brain death in patients with hypoxic/ischaemic encephalopathy as early therapeutic hypothermia is now widely used in these patients. A review of available publications suggests that neurological recovery may not be immediate on regaining normothermia. A conservative approach will be recommended, with a delay of at least 24 hours after the return of normothermia before clinical determination of brain death, and then only after all of the other conditions have been met. Neuro-imaging to demonstrate absent intracranial blood flow remains an option if confirmation of brain death is time critical.

A recent survey by a group from Sir Charles Gairdner Hospital has shown a very high level of support among respondents for the approach and criteria set out in the ANZICS

Statement for the Determination of Brain Death. We hope the details of the findings will be published in the near future. The hormone resuscitation project is also progressing, with a chapter and a systematic review having been submitted and works on a prospective observational study in hand.

This will be my last report for *The Intensivist* as Chair of the Committee. I will be standing down due to other commitments. At the recent Committee teleconference Bill Silvester was elected as the new Chairman, which was endorsed at the recent ANZICS Board meeting. Bill will assume this role from 14th July and will be leading a Committee with immense expertise and experience in organ and tissue donation. The change in Chairman was well overdue – I have been in the Chair since 2000, having previously been Deputy Chairman 1995-2000 and a member since 1992. This period covers all the editions of the ANZICS Statement to date. I would also like to take this opportunity to thank all the members of the Committee over this time for their support, hard work and expert input. I will remain on the Committee for a further six months to ensure a smooth transition.

Professor Geoff Dobb
Death and Organ Donation
Committee Chair

Paediatric Report



The 6th World Congress in Pediatric Intensive Care was held in Sydney in March, with years of careful planning coming to fruition

in brilliant fashion. The Congress was a resounding critical success with attendees from over 130 countries. The scientific programme was varied, innovative and cutting edge with excellent speakers from the region and around the world. The social programme included a Sydney Harbour cruise and Sydney was on its best behaviour weatherwise.

This was a fantastic opportunity for intensive care doctors and nurses in Australia and New Zealand, being a smaller specialty, to catch up with acquaintances and colleagues from all over the world.

The World Congress kicked off on Sunday with the 2 km Sydney Harbour swim, with several Congress attendees braving the apparently shark infested water. The scientific programme began in earnest on Monday and continued for four days. Enormous thanks must go to David Schell, Tina Kendrick and the entire Organising Committee. Our thanks also must go to the conference organisers, Arinex, who ran an extremely well-organised meeting. The next PICU World Congress will be held in Istanbul in 2014.

Paediatric Study Group

I have been elected as the new Chair of the Paediatric Study Group. I would like to thank Michael Yung, on behalf of ANZICS, for his excellent work in chairing the PSG for the past four years.

Michael Yung convened a multinational meeting of PICU research groups as a satellite meeting with the Sydney World Congress. This was a great success with research groups from Europe, Canada, USA, Australia and New Zealand all taking part. This meeting will now become a regular event at the

World Congress and hopefully lead to some meaningful collaborative clinical trials in paediatric intensive care.

Safe-EPIC Proposal

A three-day point prevalence study was 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.

CLOTS Study

The study involves a randomised trial of heparin versus placebo to prevent thrombosis and infection in central lines in PICU. The study is funded by a grant from the South Australian Women's and Children's Hospital Foundation and Michael Yung is the PI.

Paediatric H1N1 Study

The study is a collaboration between the INFINITE investigators and the Paediatric Study Group to report on the PICU burden of the H1N1 pandemic. The manuscript has been published in *Pediatrics* (2011; 127).

SPICE

The paediatric units are meeting with the SPICE Committee and there is a paediatric arm planned for the SPICE study.

ANZPIC Registry

The 2008 ANZPIC Report has been released.

An audit has recently been performed assessing the correlation between

RACHS (cardiac surgical risk category) scoring by intensivists for the ANZPIC registry and cardiology. The results are currently being analysed.

Brisbane ASM

The scientific programme for the Brisbane ASM includes a two-day paediatric component. The paediatric convenors are Kevin Plumpton, Christian Stocker and Debbie Long. International speakers are Dr Peter Weinstock, Director of the simulation program at the Children's Hospital, Boston and Dr Sharon Irving, a nurse practitioner and lecturer at the School of Nursing, University of Pennsylvania.

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 (slowly!) 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 and has taken up the cause and a meeting will be arranged with him shortly.

Simon Erickson Paediatrics Chair

Committee Membership:

Chair: Simon Erickson (WA)

Committee: Michael Yung (SA), Gary Williams, Marino Festa (NSW), Warwick Butt (VIC), Andreas Schibler, Tony Slater (QLD), John Beca, Gabrielle Nutthal (NZ)



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Education Committee

It is my pleasure to update you all on the progress of the recently formed ANZICS Education Committee.

The Committee has been formed to guide and develop ANZICS educational activities and will act as a resource for groups or individuals wanting to run meetings, courses or seminars.

The inaugural meeting of the Committee was held in Melbourne in late May and was well attended by representatives from most regions.

At the meeting the Committee formulated an agenda, which will see us address a variety of issues in order to assist the Society to develop a clear and effective capacity to facilitate the provision of quality opportunities to its members.

The Committee also indicated that it intends to address the issues facing

rural and regional educational events and develop initiatives to increase attendance and participation at a local level.

The Committee's Terms of Reference are available on the ANZICS website: <http://www.anzics.com.au/committees/education/240-education-committee-terms-of-reference>

This committee will work closely with the College of Intensive Care Medicine to develop a shared vision and commitment to supporting members of the Society and colleagues who practice intensive care medicine in their ongoing requirements for professional education, development and training.

I would encourage you to get in touch with your regional representatives if you have any questions or suggestions.

Committee Membership:

Gerry O'Callaghan (Chair) (SA)
Stephen Warrillow (Deputy Chair) (VIC)
Michael O'Leary (NSW)
Mary White (SA)
Arthas Flabouris (SA)
Simon Erickson (WA)
Charudatt Shirwadkar (NSW)
Dhaval Ghelani (NSW)
Elizabeth Fugaccia (NSW)
Sumeet Rai (NSW)
Owen Roodenburg (VIC)
Sam Radford (VIC)
Matthew Keys (QLD)
Alex Psirides (NZ)

Gerry O'Callaghan
Education Committee Chair

Safety & Quality Committee



The Safety and Quality Committee has taken a significant and exciting step forward in the past six months with the appointment

of Jennifer Holmes as Executive Officer. Jennifer is eager to assist the Committee develop and promote the group's initiatives and we welcome her into the role.

Last year the Australian Commission on Safety and Quality in Health Care published its Australian Guidelines for the Prevention and Control of Infection in Health Care (2010). In it there are a number of recommendations relating to VAP and CLABSI in the ICU. The Safety and Quality Committee previously conducted a survey of Australian intensive care clinicians to obtain local opinion about the most relevant ventilator-associated pneumonia prevention strategies.

The results have been used to develop a Care of the Ventilated Patient Consensus Statement. A draft document has commenced circulation within the Committee, with plans for a workshop to be held at the 5th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (see below).

The Safety and Quality Committee is excited to be working on the development of our own blog on the ANZICS website. The aim of the blog is to provide a forum for sharing of opinions, encouraging healthy debate and welcoming new connections.

5th International Conference on Safety, Quality, Audit & Outcomes Research in Intensive Care (SQAO 2011)

The 5th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive

Care (SQAO 2011) is taking place in the beautiful Hunter Valley, NSW at the Crowne Plaza, from Monday 1st – Wednesday 3rd August. This year's exciting program will cover a broad range of topics, exploring the domains of quality – structure, process, outcomes and culture. Guest speakers include Dr Craig Lilly from Massachusetts, USA as well as Professor Mari Botti (Professor of Nursing, Deakin University) and Professor Enrico Coiera (Professor Medical Informatics, UNSW). This year is again encouraging development of new safety and outcomes initiatives with interactive sessions, open discussions and free paper presentations. For further information, please refer to the SQAO 2011 website www.sqao2011.com. Also, for the first time this year, the Safety and Quality Committee is excited to be offering up to \$15,000 of seed funding to support safety and quality projects.



2011

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5th International Conference on
Safety Quality Audit & Outcomes
Research in Intensive Care
Hunter Valley, Australia
1-3 August 2011

www.sqao2011.com

Safety & Quality Committee Meetings

The next Committee meeting will be held on Monday 1st August at 1200hrs at the Crowne Plaza Hunter Valley. The Committee would also like to take this opportunity to invite you to attend the Care of the Ventilated Consensus Patient Statement workshop on Monday 1st August at 1400hrs. This is a fantastic opportunity to have your say in developing consensus recommendations for care of the ventilated patient with a focus on preventing ventilated-associated pneumonia.

The membership of the Safety and Quality Committee is up for review in October 2011. Those with an interest in joining or working with the Committee, please feel free to contact Jennifer.Holmes@anzics.com.au for further information.

Anthony Burrell
Safety & Quality Committee Chair

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Generate your completion certificate to record your participation and substantiate CME/CNE points.

www.asklepios.com.au

Online learning guide

Developments in sedation management in critical care: a focus on analgesia-based sedation

Online presentation

Tuesday 23 August 2011. Presentation to commence at 7.30pm AEST

Optimal sedation in the ICU: a focus on remifentanyl

Presenter

Dr Carl Waldmann
Royal Berkshire Hospital, UK

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Monday 5 – Sunday 18 September 2011

Learning guide expert reviewers and forum moderators

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Prince of Wales Hospital, NSW

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University of Technology, NSW

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Alfred Hospital, VIC

Assoc Prof Michael Reade
Austin Hospital, VIC

Dr Ian Seppelt
Nepean Hospital, NSW
Dr Carl Waldmann
Royal Berkshire Hospital, UK

Ms Leonie Weisbrodt
Nepean Hospital, NSW

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