

# The Intensivist

## Increasing the Profile of Intensive Care – Can We Do It?



*'My Coma Dreams', a jazz theatre by Fred Hersch recounting his experiences of intensive care, performed in Berlin for the ESICM.*

"How's it going in emergency, doc?" asked my flying instructor yet again! I could not recall how many times I had told him that it was in the intensive care unit and NOT the emergency department that I worked. "So what exactly do you do there?" he followed up. I'm sure we'd covered this ground before too, but with my explanation his

face became increasingly blank, not really understanding exactly what this role entailed.

I am sure many of you will have experienced a similar conversation. It's frustrating, but in fact it is actually worse than that, because our failure to have an identity within the community at large has important implications

for our specialty. This has become most apparent to me in my roles with the Intensive Care Foundation, initially as Chair of the Co-operative, the group of medical device and pharmaceutical companies that support the Foundation financially, and most recently as a member of the Foundation Board. We all recall

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### **ANZICS Board**

M.White (President), M.O'Leary (Immediate Past 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).

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the Intensive Care Appeal, with the wristband sales and so on. Despite an enormous amount of hard work by a number of people this never really gained traction and failed to bring in a level of income that justified us continuing with it. Attempts to involve the media in promoting the specialty to link in with this were of only limited success, which is somewhat surprising as other 'high-tech' areas of medicine seem to find it much easier to be popular. At least in Australia and New Zealand intensive care medicine is recognised as a medical specialty – elsewhere I often struggle to work out what to list myself as in the drop down menu. Anaesthetist? Well I've not really done that for over 15 years!

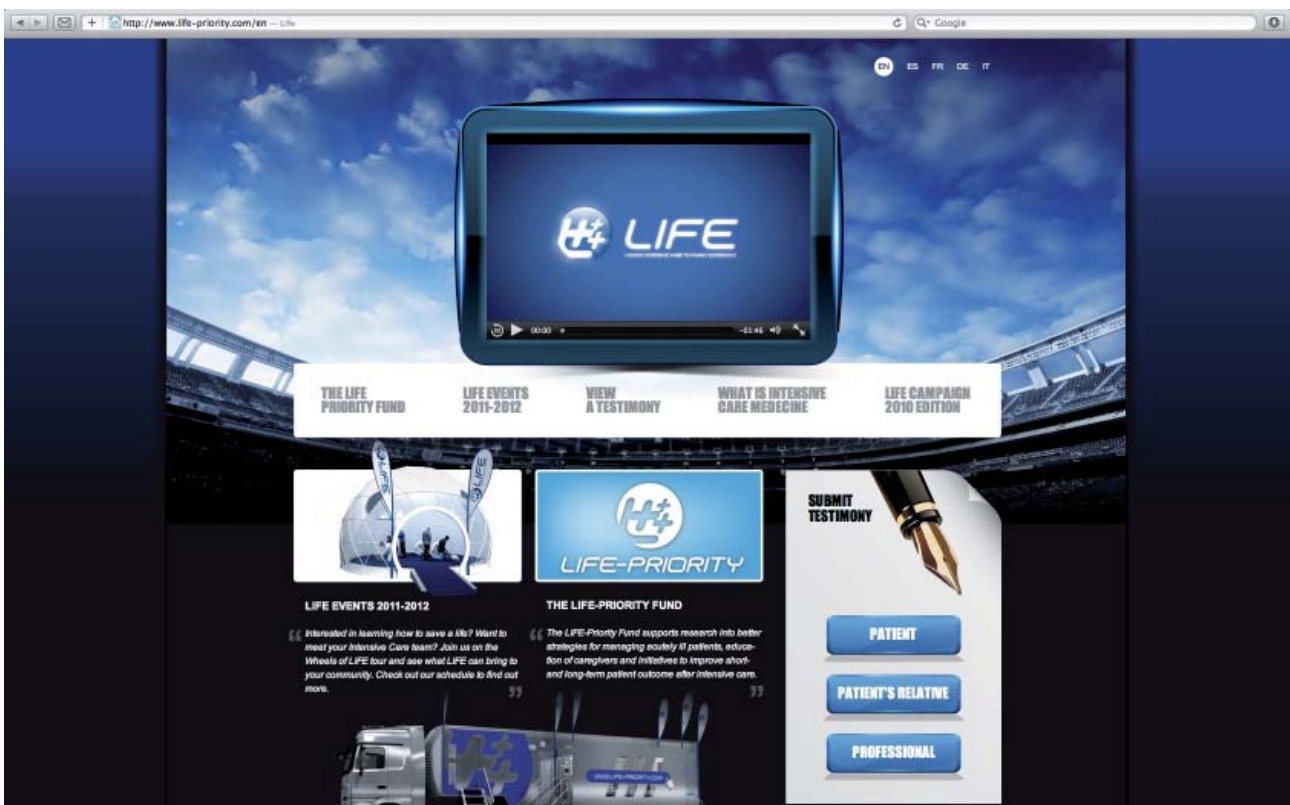
Apart from the effect on fundraising, not having a high-profile identity also has other important impacts. Even in the arena of organ donation the media, and thus the community, are not clear that it is intensive care specialists that are the main players in the process of obtaining good quality organs for donation. Without an adequate profile I doubt we will get the major community debate about end-of-life care or the

provision of high-technology medicine to people in their final months of life that we really need if we are to ensure we continue to 'do the right thing' for our patients and use the constrained health budget ethically and wisely. I don't think that we are asked frequently enough for our input to planning the delivery of acute hospital services either locally or nationally.

As a specialty intensive care medicine ought to have a higher profile internationally, but certainly so within Australia and New Zealand. Our forebears were pioneers of the specialty internationally and we are rightly proud of their achievements. Among our colleagues across the world we are certainly held in high esteem; our system of training and examinations is recognised as second to none, and most recently the achievements of the ANZICS Clinical Trials Group have put our researchers at the front of the world stage. Despite this, the community at large knows very little about us. Popular campaigns highlight the impact of cancer and heart disease, for example, and these conditions therefore have a high profile

and a better ability to obtain charitable donations. Few people recognise that an ICU disease such as sepsis affects at least as many individuals as many of the most recognised cancers and has similar mortality rates. The fact that death rates for patients admitted to intensive care in Australia and New Zealand are better than those of comparable patients in North America and Europe should be common knowledge.

Can anything be done about this problem of low profile? Possibly not. Certainly we should each be taking every opportunity we can to advertise our success locally to colleagues from other specialties and to the community, but beyond this it becomes a bit more difficult. A couple of years ago Yahya Shehabi and I were involved in a teleconference with the Executive of the SCCM in the US and we asked if they had any advice regarding profile and fundraising for research. They replied that they had been intending to ask us the same question! Despite, they claimed, a significant amount of effort and expense they felt that they had not



The LIFE-Priority Fund web page, showing at the bottom a cartoon of the Wheels of LIFE truck, which will visit top soccer clubs across Europe.

managed to significantly increase their profile. The SCCM has a well-developed patient/relative information website ([www.myicucare.org](http://www.myicucare.org)), however, they said that this received a poor level of hits per month. They commented that their experience was quite different to that of their emergency medicine colleagues and they put this down to the positive effect of the television program E.R. and George Clooney...

I have, however, become quite impressed with an initiative that is currently underway by the European Society of Intensive Care Medicine and wonder if there is anything we in Australia and New Zealand can learn from this. A couple of years ago Jean-Daniel Chiche and Andrew Rhodes embarked on a new strategy to increase the profile of intensive care medicine across Europe. They came up with the catchy acronym LIFE for their campaign – ‘Linking Intensive Care to Family Experience’. Initially they put out a call for ESICM members to encourage ex-patients and their families to submit letters to the campaign to highlight their experiences of intensive care and (hopefully) their gratitude for good outcomes and/or good quality care. They have gone on to identify high-profile individuals that have experienced intensive care and are willing to lend their support to the campaign. One is Fred Hersch, an internationally acclaimed jazz pianist who developed a severe respiratory infection and required many weeks of intensive care, including tracheostomy. Fred Hersch has written and spoken about his intensive care experience for the campaign and has written a jazz theatre based on his experiences, ‘My Coma Dreams’, which received a special performance in association with the Berlin ESICM Annual Congress (see [www.mycomadreams.com](http://www.mycomadreams.com)).

Another high-profile ex-patient is the French soccer player Eric Abidal. Abidal developed a liver tumor and had this resected on 17th March this year. Despite this, he was fit enough to play the entire game when Barcelona beat Manchester United 3-1 at Wembley Stadium, London on

28th May. In recognition of his gratitude to the intensive care staff that looked after him, Eric Abidal agreed to feature in a video advertisement for the LIFE-Priority Fund set up by the ESICM as a development of the LIFE campaign. The video is a very slick and professional production and can be viewed online at [www.life-priority.com](http://www.life-priority.com).

The LIFE campaign also organised an attempt to train the greatest ever number of people in CPR in Berlin just before the Congress, and this was widely covered in the German media. The campaign has also fitted out an impressive ICU truck that will become a travelling ICU roadshow. ‘The Wheels of LIFE’ will be an educational tour geared towards teaching CPR and raising awareness about intensive care medicine. During its first tour the Wheels of LIFE truck will visit stadiums of 11 top-grade football clubs in five European countries. Football fans and invitees from clubs or national federations will be trained to perform CPR and will be given opportunities to visit a fully-equipped ICU room.

While the aim of these initiatives is to raise the profile of the specialty, the result, it is hoped, is that this will translate into donations that can be used to fund ongoing clinical research and also community education campaigns. The LIFE campaign now includes the LIFE-Priority Fund, which will be utilised for these purposes.

These initiatives are interesting, but the general concept, of course, is not new and we have suggested similar initiatives here in the past. Our Intensive Care Foundation has asked for testimonials from ex-patients and relatives, we have tried to identify high-profile ex-patients, and most recently Yahya Shehabi has established ICF Facebook and YouTube pages. Nonetheless, I feel that the level to which the ESICM seems to be aspiring with the LIFE campaign could be an inspiration for us.

The Intensive Care Foundation may be at a crossroads: we have not

managed to significantly increase our income for many years and income from our investment portfolio has stagnated with the global financial crisis. Grant funds annually are static and comprise as little as 10% of the amount requested. Those of us that have been involved with the ICF for some time recognise that the public appeal has become fairly fruitless, as competing in a heavily over-subscribed market for the charitable dollar without a clear profile is very difficult. Our current strategy has moved to looking for a small number of corporate sponsors willing to commit to the ICF over a number of years and this is, I believe, the only realistic way we can build the ICF in the short term. To get to be a significant player in the longer term, however, will need a much greater level of broad community support than at present and this can only be achieved by building our profile. Approaching and cultivating high-profile ex-patients, running promotional events, maintaining a dynamic website and social media pages all take considerable time and effort however and this may be an insurmountable hurdle for us given how busy we all are already in our daily work.

The easiest option for us to do nothing, but then I think we will never increase our influence with policy makers or be able to drive important debate in the community and we will have only very limited ability to develop start-up research projects. I think that developing a strategy to promote the profile of the specialty should be an important agenda for both ANZICS and the ICF working together. Maybe it would be possible to collaborate with overseas bodies such as the ESICM, SCCM and Global Sepsis Alliance in developing our strategies. I am sure that there are members of ANZICS out there that have good media skills, great drive and good ideas – we need you to step forward and to offer to play a role in this important endeavor for our specialty.

**Michael O’Leary**  
**Immediate Past President**

# President's Report



Having attended my first ANZICS Board meeting in 2002 as the SA Regional Chair I am honoured now to begin my term as President of this great

Society. I would firstly like to thank my predecessor Michael O'Leary for his hard work and dedication over the past two years. Michael has an incredible ability to achieve a lot while making it look easy. In my first week in the role I have already realised just how much work happens behind the scenes. I am glad that Michael will remain on the Executive as Immediate Past President to offer his advice and assistance.

In his role as Immediate Past President Michael will primarily be responsible for liaising with the Rural and Regional Special Interest Group. An email list of rural and regional members was recently established and we hope to work closely with the College of Intensive Care Medicine (CICM) to provide these members with the support that they require. We hope that the recently-established LinksPersons group will also be instrumental in this support.

The strength of ANZICS has been and always will be in the hard work of its members. One member who has contributed to the Society, intensive care and the greater medical community in an extraordinary manner is Geoff Dobb. Geoff has recently stepped down from the position of Chair of the Death and Organ Donation Committee, having served in the role since the inception of the Committee in 2000. ANZICS is an authority in this area not only in Australia and New Zealand but also internationally. For this, we owe Geoff a huge debt of gratitude. I would like to thank him for his commitment and service over those many years and wish him well in his role with the AMA. Geoff's position in Death and

Organ Donation has been taken over by Bill Silvester, who I know will do an excellent job.

We have just returned from another great ASM, which was held in Brisbane this year. I would like to thank Marc Ziegenfuss and his committee for the huge amount of work that went into making it such a success. There was an impressive range of both local and international speakers who provided us with great insight into new technologies. For those of you who had the privilege of hearing Brad Power, I am sure you would agree that his oration will go down in the annals.

The recent round of NHMRC grants has seen ANZICS members yet again at the forefront of research. The CTG has performed the usual tour de force with grants of over \$5 million being awarded by the NHMRC to CTG-endorsed projects. A number of ANZICS members have also been successful in individual grant applications. It is also very important to encourage and foster research among our trainees. I would ask you to remind registrars of the opportunities to present at the ASM and compete for the Matt Spence Medal. I would also like to thank the Intensive Care Foundation for the ongoing support for research projects that it provides.

I am pleased to report that the proposed move of ANZICS CORE to Monash University has been approved by the Board and the plans are now at an advanced stage. We await the outcome of final discussions.

The Board has approved funding for the Education Committee, with Gerry O'Callaghan as Chair, to conduct a stocktake of current post-graduate education and training, which will analyse what opportunities currently exist and what opportunities members need. The project commenced with a survey of a representative sample of ASM attendees and will focus on identifying what is of ongoing interest to ANZICS members. If you were one of those who were involved in the

survey we would be very grateful if you would respond to any additional questionnaires. As you are all aware the Board is very keen to address the needs of ANZICS members in this very important area.

Stephen Warrillow and Gabby Hanlon from the ACCCN continue to work on the bid for the World Federation of Societies of Intensive and Critical Care Medicine World Congress for 2017. We wish them well on their trip to Colombia for the formal bid presentation.

Following our successful joint meeting with our Singaporean colleagues in April we are planning another meeting to be held in Singapore in 2013. A number of members have already indicated their willingness to organise this meeting.

With regard to the future, questions are regularly asked about the relationship between ANZICS and the new CICM and particularly where each places itself within the intensive care community. ANZICS has a long and proud track record over the past 36 years in what has been and currently is delivered through the work of our members and the committees. ANZICS committee outcomes impact on every aspect of intensive care practice; Safety and Quality, CORE and Death and Organ Donation inform many of our clinical decisions. We are all aware of the huge importance of research in any dynamic speciality. The work of the CTG, and indeed all of our researchers, is pivotal. I think that we are a vibrant, active and truly relevant Society. I would like to see an increase in membership, particularly trainees. I would also like to see the Education Committee become a well-established and key committee of the Society, coordinating and answering the educational needs of our members.

Health Workforce Australia (HWA) is currently developing a National Training Plan for doctors and nurses, with the aim of estimating workforce

requirements to achieve self-sufficiency in health professional supply by 2025. A meeting of an Intensivists Clinical Advisory Group with representation from ANZICS and the CICM was convened in October by HWA, at which modelling of future intensive care workforce requirements was presented. Nick Edwards from the PricE Committee represented the Society.

Our speciality is relatively young and we are probably behind some of

the older specialities in the area of workforce planning. There are some very useful data within CORE, which could potentially provide a framework for informed planning. I would like to see ANZICS working closely with the CICM in this as there are obvious overlaps and synergies and who better to facilitate this planning than the PricE Committee? We have a duty to our trainees, to ourselves and indeed to the community to manage and plan

our speciality and our resources in a responsible and informed manner.

My job as President is to continue to foster and facilitate the great work of our Society and our members. I look forward to a fruitful and collaborative relationship with the CICM, working towards the advancement of intensive care.

**Mary White**  
**President**

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## South Australian Coronial Inquest



In March this year the South Australian Coroner brought down his findings and recommendations following the inquest into the death of an

elderly lady in the ICU at Flinders Medical Centre after cardiac surgery. The Coroner's findings have generated discussion within the intensive care community. The ANZICS Board has considered the Coroner's recommendations and I have the following comments that I hope members will find helpful.

The results of a coronial inquest are centered around an individual case at a specific institution. Consequently, the conclusions and recommendations may not be readily generalisable to other clinical situations, institutions or health jurisdictions. In Australia, ANZICS and the College of Intensive Care Medicine (CICM) are committed

to providing standards and education in intensive care and to support research and its translation into practice in accordance with the highest standards. We are rightly proud of our achievements over the past 30 years and can state with some confidence that the high quality of our practice is recognised worldwide.

Intensive care specialists are cognisant that where clinical decision-making and practice interacts with other medical and surgical disciplines, the role and expertise of each specialist needs to be recognised. Moreover, it is essential that the management of a critically ill surgical patient is conducted in the framework of a team, including surgeons, anaesthetists, intensivists, other medical specialists, nurses, physiotherapists, and other healthcare professionals. The intensivist is responsible for coordinating all aspects of care with input from the other team members and must be the final decision maker when there

is uncertainty. Communication and collaboration are mainstays of multi-disciplinary team management; it is important that major changes in management or in a patient's clinical condition are communicated to parent medical or surgical specialists in a timely manner.

A vital part of medical practice is training our junior doctors to be the specialists of tomorrow. The 'apprenticeship' model where a junior is gradually allowed to take on more responsibilities is well tried and tested. It will always fall to the intensivist in charge on the day to decide the appropriate level of responsibility an individual junior doctor may undertake.

Members should be aware of the coronial legal process when participating and consider the need to obtain independent legal counsel at all times.

**Michael O'Leary**  
**Immediate Past President**  
**ANZICS**

# Regional Reports

## New South Wales



NSW ANZICS has been busy recently and it is heartening to see an increased interest in the Society's activities, as well as an increase in

membership applications, particularly from trainee members. We currently have 159 members, 21 of whom are new members this year.

Since our last report we have conducted two education sessions. The sessions were co-badged with CICM and attendance was impressive. St Vincent's Hospital conducted a session titled 'Dilemmas of the Heart', while Westmead ICU presented 'Dosing Matters'. We also conducted a small group session for trainees, which focused on hands-on management of IABP and pacemakers in the ICU, as well as a session on reporting of CT scans by Professor Magnussen.

There is broad support in NSW for ANZICS to maintain an ongoing role in the professional development and welfare of intensivists. The ANZICS LinkPersons initiative has been developed to address this issue and we now have LinkPersons in a number of NSW ICUs.

We hope to conduct regional meetings in the coming year and, as always, we are keen for enthusiastic members to volunteer to become involved with ANZICS committees at a state or bi-national level. If you are interested in joining a committee or you have some suggestions, please don't hesitate to contact one of those named below.

Peter Harrigan stepped down as the NSW ANZICS CTG representative this year. We thank Peter for his contribution to promoting CTG research in NSW and welcome David Gattas, who has taken over Peter's role.

Mark Lucey has indicated that he would like to step down from the NSW ANZICS Executive. I would like to thank Mark for his valuable contribution to

NSW ANZICS over the last few years. Mark was vital in organising the education session at the Royal Prince Alfred Hospital and his calm and thoughtful input will be missed.

### **ANZICS NSW Regional Committee**

Chair: Deepak Bhonagiri

Members: Mark Nicholls

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

Executive Michael O'Leary  
(Immediate Past President)

PRiCE Committee: Mark Nicholls

CTG: Ian Seppelt, David Gattas

Death & Organ Donation Committee:  
Deepak Bhonagiri

Safety & Quality Committee:  
Tony Burrell (Chair)

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

## New Zealand



This year's NZ ANZICS meeting will be held on Monday 14th November between 10.00am – 4.00pm at Wellington Hospital, with the

theme focusing on the Christchurch earthquake from an ICU perspective. Contact Peter Hicks or Dick Dinsdale if you have any questions.

Unfortunately the 2011 ICU Registrars Conference that Waikato had organised did not go ahead as there were not enough registrants. I would therefore greatly encourage trainees to attend Wellington's exam revision course on 15th – 17th March 2012; the previous Wellington course was well received by all. ICM trainees have been making ad-hoc visits throughout New Zealand to hospitals they do not usually work at for Part II exam practice; please advise your ICM trainees that this opportunity is available, provided early warning is given.

The high dose vitamin C issue seems to be fairly quiet at present, probably due to the decline in the number of H1N1 cases requiring ICU care. There is to be discussion with the Medical Protection Society on future approaches regarding demands for alternative therapies in the ICU; please let me know if you have suggestions on the matter.

Don't forget to send details of intensive care related courses to Alex Psirides as he is the NZ representative on the ANZICS Education Committee. Suggestions for how ANZICS could better provide ICM educational resources would also be welcomed.

David Knight will assume the position of NZ ANZICS Chair from 2012 and I trust that he will do well in his new role.

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

## Queensland



The Queensland Regional Committee has had a busy few months preparing for the 2011 ASM, which was hosted in the beautiful city of Brisbane.

The theme of the meeting was 'Tools of the Trade - Tips, Tricks and Technology' and it certainly delivered a tremendous educational experience. Jeff Presneill, Chair of the Medical Scientific Committee, is to be congratulated on an outstanding scientific program. The feedback from the delegates has been very positive, with many commenting on a diverse program, which provided something for everyone. The Committee worked hard and succeeded in securing industry sponsorship in difficult times, they also excelled in putting a social program together that has raised the bar to yet a new level. I would like to express my sincere appreciation for all the incredible hard work that went into making the 2011 ANZICS/ACCCN

ASM such a tremendous success. Thank you one and all!

Our state continues to lead the pack with respect to an intensive care training pathway. The ICU Training Pathway has completed its third year of centralised recruitment, with significant improvements in state-wide training capacity. The Pathway is working in conjunction with accredited units and the CICM to promote and advance the training needs of ICU vocational trainees. The Pathway aims to provide a structure to the local training, such that trainees are guided through both their basic and advanced training in a coordinated fashion. This approach has generated a healthy number of applicants for both registrar and senior registrar appointments for the 2012 year. QLD ANZICS has also seen a steady increase in new memberships.

On the research front it has been an excellent year for Queensland. We are very proud of the Queenslanders who are the principle investigators in the ESCAPE trial, which has secured a \$3.2 million NHMRC grant to settle the question of steroids in sepsis. The CICM / ANZICS Registrar Research Forum provides an opportunity for established researchers to mentor and encourage new researchers. The first meeting was conducted in November 2010 and was very well received and even achieved interstate attendance. The meeting provides a wonderful opportunity for the presentation of trainee papers. ANZICS will again be supporting the Queensland Registrar Research Forum and strongly encourages trainees to consider attending.

This year has also seen the committee develop a series of 'Queensland ANZICS Lectures-Tapping into Local Expertise'. These informal dinner meetings have provided a platform for local speakers with international reputations to present locally.

This is an initiative we will certainly continue in 2012 and we look forward to more informative and educational presentations from talented local intensivists.

QLD ANZICS continues to have a strong and increasing membership representing the members' interests in a range of activities, including safety, quality, research and private practice. We aim to provide our members with a powerful and relevant Society.

**Anthony Holley  
Queensland Chair**

**ANZICS QLD Regional Committee**

Brent Richards (Organ Donation)

Dan Mullany (CORE)

Ranald Pascoe (PricE)

Peter Kruger (CTG)

John Evans (Secretary)

**South Australia**



The current focus in South Australia is on the 2012 ASM, which is being held 25th – 27th October. Ken Lee, Adam Deane and their team are well

advanced in the planning. A draft program has been arranged and overseas speakers formalised. The theme is 'Intensive Care – It's not all Black & White'. Come along and join in – even if you don't enjoy the medicine, the weather in Adelaide in October is perfect for long vineyard lunches.

Brett Sampson has stepped down as the Safety and Quality Committee representative for SA due to commitments with Donate Life. A replacement has yet to be found.

I shall be stepping down as SA Regional Chair at the end of the year. A replacement has not yet been finalised, but discussions are ongoing.

**David Durham  
South Australian Regional Chair**

**Victoria**



One of the most common frustrations for intensivists is the late referral of an acutely unwell ward patient. Given

the mounting evidence that delayed escalation of care contributes to suboptimal outcomes, there is surely an imperative to improve. Knowing the reasons for delayed escalation would be helpful for planning ways to deal with it. The causes are multifactorial and include the inability to detect deterioration, the misdiagnosis of deterioration and the initiation of ill-timed, ineffective or insufficient therapies. The widespread introduction of rapid response teams (RRTs) over the last decade has undoubtedly provided a crucial safety net for ward patients and has led to improved outcomes. However, the current model of such teams does not prevent all instances of poor outcome, due to frequent failures of activation. Despite intense education about the role of RRTs when such processes are introduced at a hospital, lengthy periods of significant physiological instability often occur prior to the RRT being summoned. Such problems persist even in hospitals where RRT systems are very well established. To address this will take considerable effort.

Improved physiological monitoring on wards is one possible strategy and the means of achieving this on general wards is likely to evolve dramatically in the near future. Education is another key element. Providing ward-based medical and nursing staff with fundamental critical care skills would seem crucial to improving outcomes for patients under their care. Intensivists may be concerned by the perceived lack of such skills outside of ICU, but perhaps we have, to some degree, unwittingly contributed to this situation. One of the few potentially legitimate criticisms of RRTs is the possibility that they may indeed accelerate a process of

de-skilling ward staff because the 'ICU cavalry' arrive to save the patient and provide little immediate feedback or educational support to the junior ward staff who initiated the call in the first place. In addition, as critical care training has matured into a distinct career pathway, many other training programs appear to have de-emphasised the acquisition of relevant acute care skills and knowledge. It would seem that if intensive care is increasingly the major repository of critical care ability within hospitals, we have a responsibility to provide educational support to ward staff to ensure that gaps in capability are minimised. Several initiatives are emerging to achieve this.

Some colleges have implemented compulsory programs to teach the fundamentals of critical care to their trainees (e.g. the RACS requires all trainees to complete CCrISP) and intensivists are frequently found on the faculty of such courses. Similarly, many hospitals have introduced BASIC courses for new junior staff rotating through the ICU. Such programs are laudable and clearly tap into a strong need, but their focus may be too narrow to achieve the broader penetration required to give a very large cross section of junior

ward-based medical staff sufficient exposure.

In Victoria Ramesh Nagappan has been running a three-day acute care medicine course out of Box Hill Hospital for many years with great success. The ever-increasing attendance (to the point of oversubscription) is testament to both the quality of the program and the demand for such education. At a hospital level, many institutions provide schedules of fundamental critical care education for junior ward staff. I have been involved in several of these across various Victorian sites and find a very keen interest among the junior doctors, who have often stated that opportunities to learn these skills are few in the undergraduate and resident years. Intensivists are fortunate that the knowledge and skills we are able to impart are highly valued by junior doctors. Essential skills of clinical evaluation (e.g. sick versus not-sick) and management tips on basic therapies such as oxygen or intravenous fluids are eagerly sought after and we are well placed to educate. There is also increasing state and federal interest in improving standards of care for deteriorating patients, such that improved opportunities for the resourcing of

such initiatives may be imminent. While the primary intent of such engagement with junior ward staff is to improve the level of care outside the ICU, a secondary benefit is the opportunity to inspire some of the best and brightest junior doctors to consider training in intensive care. So many of us were inspired to pursue ICU training after encountering senior intensivists who provided dedicated teaching and mentorship and it is hard to overstate the long-term importance of this to our advanced training programs.

While CICM is responsible for intensive care specialist education and training and ANZICS takes a lead role in ongoing educational support of practising clinicians, there is significant opportunity for all intensivists to invest effort in the educational support of junior ward staff. The recently formed ANZICS Education Committee provides a forum for discussing ideas and experience relating to all critical care educational initiatives and welcomes intensivists to share their experience of locally successful programs that might be of interest to the broader membership.

**Stephen Warrillow**  
Victorian Chair

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## ANZICS Honour Roll

**The ANZICS Board would like to congratulate the following members on their appointment to the ANZICS Honour Roll:**

A/Prof Graeme Hart

Prof Rinaldo Bellomo

Dr Brad Power

Prof Jeff Lipman

Prof Simon Finfer

Dr Mike Hunter

Prof Ken Hillman

## ANZICS ASM Awards 2011

**The ANZICS Board would like to congratulate the following ANZICS/ACCCN ASM 2011 prize winners:**

### **Best Medical Paper**

Adam Deane

*Erythromycin does not reduce small intestinal nutrient absorption in the critically ill*

Graeme Duke

*Ten-year review of intensive care services in Victoria*

### **Matt Spence Medal**

John Raj

*Waist circumferences correlates with obesity and morbidity better than BMI in intensive care patients*

### **Safety & Quality Best Paper**

Claire Rickard

*Peripheral intravenous catheters can be left in situ until clinically indicated for removal: randomised controlled trial*

### **ANZICS CORE Best Paper**

Glenn Eastwood

*Arterial oxygen tension and mortality in mechanically ventilated patients*

### **ANZICS CORE Best Publication**

Deepak Bhonagiri

*Increased mortality associated with after-hours and weekend admission to the intensive care unit a retrospective analysis*

## Membership Report



This year has seen ANZICS grow to 704 members. This is a great achievement for our Society and I wish

to express my gratitude to all our members, Regional Chairs, LinkPersons and committee members who have helped promote and spread the word of ANZICS and the work it does for its members. Although ANZICS has been successful in recruiting new members, I must encourage all ANZICS members to continue to promote ANZICS and encourage people working within our speciality to join ANZICS.

If you have any membership enquiries or wish to join ANZICS please contact Nathan Etinger on (03) 9340 3400 or [nathan.etinge@anzics.com.au](mailto:nathan.etinge@anzics.com.au).

I would also like to take this opportunity to welcome the following new members to the Society:

Dr Paul Grolman,  
Joondalup Private Hospital, WA

Dr Sidharth Agarwal,  
Royal Darwin Hospital, NT

Dr Sumesh Arora,  
Prince of Wales Hospital, NSW

Dr Kollengode Ramanathan,  
Royal Brisbane Hospital, QLD

Dr Yasmin Whately, Royal Brisbane  
and Women's Hospital, QLD

Dr Sanjay Tarvade,  
Royal Prince Alfred Hospital, NSW

Dr Dani Goh,  
Westmead Hospital, NSW

Dr Peter Thomas,  
Prince of Wales Hospital, NSW

Dr Sunil Gupta, Auburn Hospital, NSW

Dr Ben Gelbart,  
Geelong Hospital, VIC

Dr Daniel Seller,  
St Vincent's Hospital, VIC

Dr David Brewster,  
The Alfred Hospital, VIC

Dr Alex Kazemi,  
Auckland City Hospital, NZ

Dr Raj Kumar,  
The Prince Charles Hospital, QLD

Dr Kevin Plumpton,  
Royal Children's Hospital, QLD

Dr Madhav Pendyala,  
Westmead Hospital, NSW

Dr Mehdi Rostami,  
Frankston Hospital, VIC

Dr Oliver Flower,  
Royal North Shore Hospital, NSW

Dr Nudrat Rashid,  
Royal Prince Alfred, NSW

Ms Martina Ni Chonghaile,  
The Geelong Hospital, VIC

Dr Marianne Kirrane, Royal Brisbane &  
Women's Hospital, QLD

Dr Dinesh Parmar,  
Prince Charles Hospital, QLD

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

## Clinical Trials Group Report



The intensive care research community, including the ANZICS Clinical Trials Group, were highly successful at the

most recently announced NHMRC funding round. All four CTG-endorsed studies that applied for funding were successful. TRANSFUSE, a multicenter trial of fresh versus usual aged red cells for blood transfusion, was awarded \$2.8 million. The PHARLAP study of recruitment maneuvers with lung protective strategy in patients with ARDS obtained \$1 million. The BLING study, a phase II RCT of administration of beta-lactam antibiotics by infusion compared with bolus dosing in patients with severe

sepsis was awarded just under \$1 million and the ARISE Investigators received top-up funding of \$350,000, which was exactly the amount that had been requested. This brings the total funding of ANZICS CTG projects to over \$55 million, of which almost \$30 million has come from the NHMRC. For every \$1 that has been contributed by member units to run the CTG office there has been a return of \$55 in funding for research conducted in our ICUs. Congratulations to John Myburgh who received a highly prestigious NHMRC Practitioner Fellowship. There were also successful projects grants for Marianne Chapman (Optimisation of Nutrient Delivery and Absorption in Critically Ill Patients, \$540,000) and Adam Deane (Causes and Management of Elevated Blood Sugar in Critically Ill Patients,

\$420,000). Lastly, a Centres for Research Excellence grant was awarded \$2.5 million over five years for the Australian Resuscitations Outcome Consortium, which will be based at Monash University and is led by Professor Peter Cameron. These results confirm the quality of research that is now being undertaken to improve the outcomes of critically ill patients in Australia and New Zealand. The CTG Executive extends its congratulations to all investigators.

Stephanie O'Connor has stepped down as the representative of the ICU Research Coordinators Interest Group and will be replaced by Rachael Parke from Auckland. I would like to thank and acknowledge Stephanie's contribution to the CTG Executive

and the ICU research community. During Stephanie's time on the CTG she has championed the role of the Research Coordinator, which now includes the mandatory involvement of a Research Coordinator in the assessment of all new CTG projects that are submitted for endorsement, the organisation of a pool of Research Coordinators who are available and interested in participating in the Management Committee of CTG studies, and modification of the CTG Terms of Reference so that the Research Coordinator representative is no longer an ex officio member but now has full membership, including voting rights, on the CTG Executive. Delayed elections for CTG Office Bearers were held during the recent CTG meeting in Brisbane with the incumbents re-elected to their positions: myself as Chair, Colin McArthur as Vice-Chair, Ian Seppelt as Secretary, and Craig French as Treasurer. All Regional Chairs have now been contacted to appoint or

re-appoint a regional representative to the CTG Executive.

The CTG is taking an increasingly active international role. This includes possible participation in several multinational, multi-trials groups collaborations. These include a program of research related to selective digestive decontamination, a proposed study of genetic susceptibility to pandemic influenza, and the establishment of international infrastructure for a recurrent trial in patients with Severe Acute Respiratory Infection (community acquired pneumonia). These activities are being promoted through newly formed international networks-of-networks, including the International Forum of Acute Care Trialists (InFACT) and the International Severe Acute Respiratory Illness Consortium (ISARIC). The CTG Terms of Reference have been modified to facilitate the participation of ANZ researchers in these studies. There is also substantial interest in assisting with the formation of

new ICU-based trials groups, in particular, providing advice as well as training workshops to support the development of a newly formed Asian Critical Care Trials Group (A3CTG).

Lastly, after more than five years in the role, it is with great sadness that the CTG Executive farewells our hard working and highly productive Executive Officer Rhiannon Tate. Rhiannon has been with the CTG through a period of enormous expansion and her enthusiastic, thoughtful, and constructive approaches to supporting the CTG Executive and the research community has been a major contributing factor to the success of the group. Rhiannon has been an outstanding manager but also provided leadership to optimise the CTG's processes and to develop and implement the group's strategic plans. We wish her all the best and thank her for her contribution.

**Steve Webb**  
**Chair, CTG**

## Meetings 2012

### The ICU Research Coordinators Workshop 2012

Thursday 8 March, 2012  
Sheraton Noosa Resort & Spa, QLD

### ANZICS Clinical Trials Group 14th Annual Meeting on Clinical Trials in Intensive Care – Noosa 2012

Friday 9 - Sunday 11 March, 2012  
Sheraton Noosa Resort & Spa, QLD

### 4th ANZICS Clinical Trials Group Research Development Day 2012

Thursday 24 May, 2012  
Melbourne, VIC  
*In conjunction with the CICM ASM*

### ANZICS Clinical Trials Group Winter Research Forum 2012

Thursday 26 & Friday 27 July, 2012  
Melbourne, VIC  
*In conjunction with the SQAQO 2012*

### ANZICS Clinical Trials Group Spring Research Forum 2012

Wednesday 24 October & Thursday 25 October, 2012  
Adelaide, SA  
*In conjunction with the ANZICS/ACCCN Intensive Care ASM*

# CORE Report



There have been a number of developments at CORE over recent months.

**Monash University**

One of the most important of these developments is the approval from the ANZICS Board for CORE to relocate to become part of the registries group at Monash University. This will provide greater access to IT resources, a more academic environment to promote research collaboration and enhanced career pathways for ANZICS CORE staff. A detailed agreement is being prepared at present prior to drawing up contracts and arranging the logistics of the move.

## Annual Report

The ANZICS CORE Annual Report has now been completed and printed copies will already be on their way to your ICUs. This contains a wealth of information about intensive care practice and outcomes throughout Australia and New Zealand and about the activities of ANZICS CORE. We invite you all to read, enjoy and use the information presented in this report

## CLABSI Reporting System

ANZICS CORE, together with the Clinical Informatics and Data Management Unit at Monash University and the Australian Commission on Safety and Quality in Health Care, has been working to create a reporting system for the surveillance of central line associated bacteraemia in Australian ICUs. This is nearing completion and it is anticipated that it will begin reporting to ICUs and jurisdictional infection control bodies in early 2012.

## ASM Presentations

ANZICS CORE data provided the basis for a number of research presentations at the recent ASM in Brisbane. Glenn

Eastwood won the best presentation using ANZICS CORE data for his study entitled 'Arterial Oxygen Tension and Mortality in Mechanically Ventilated Patients'. Congratulations also go to Deepak Bhonagiri for winning the best publication using ANZICS CORE data for his paper 'Increased mortality associated with after-hours and weekend admission to the intensive care unit: a retrospective analysis', which was published earlier in the year in the Medical Journal of Australia. Other high quality presentations included those by KM Ho ('Omission of Early Thrombo-prophylaxis and Mortality in Critically Ill Patients: A Multicentre Cohort Study') and Allison van Lint ('Trained, Dedicated Data Collectors Improve the Quality of Data Collected for Clinical Registries').

## Queensland Funding

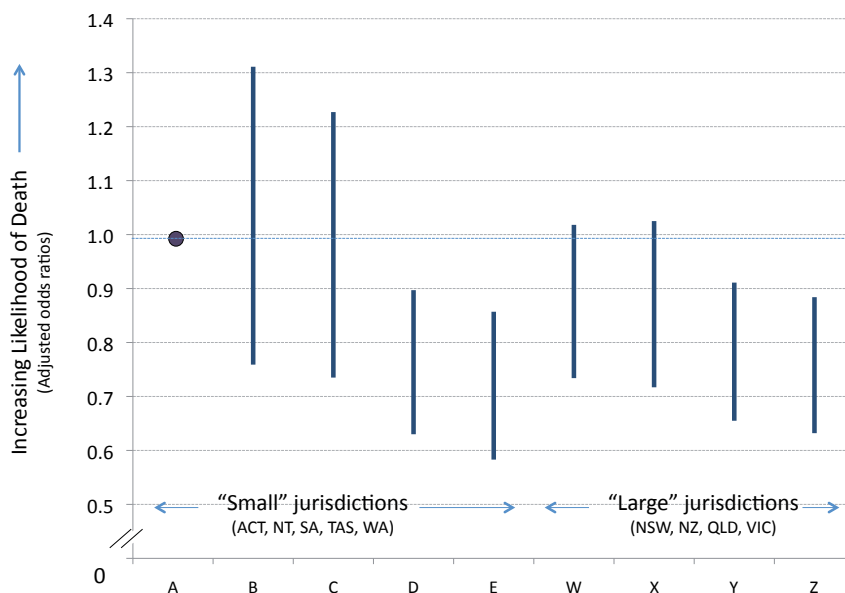
In recent years ANZICS CORE has been funded to provide services to both private and public hospitals through agreements with jurisdictional health departments. However, next year funding from Queensland Health will drop to cover only contributions from the

public sector. From July ANZICS CORE will seek individual funding contracts from private hospitals in Queensland. Contract negotiations will significantly increase the workload for ANZICS CORE. In addition there is a risk of a reduction in the number of sites that contribute to the quality assurance programs run by CORE. It is only through contributions to ANZICS that we can continue to comprehensively monitor the performance of ICUs across our two countries – a process that is the envy of other clinical registry groups throughout the world.

## Regional Comparisons

Included below is a figure which shows the relative likelihood of death after admission to ICU in the different regions of Australia and New Zealand. Odds ratios are shown as 95% confidence intervals and have been adjusted for the severity of illness and for different hospital types. They are referenced against the smallest state with the 'highest' risk-adjusted mortality (region A which has been given an odds ratio of one as a reference point). I considered

**Legend: Odds Ratios for Mortality (Adjusted for Severity of Illness and Hospital type) for All Jurisdictions in Australia and New Zealand**



presenting this figure with all or some regions identified but was wary of over-interpretation of its findings or inappropriate paranoia about this analysis, which should be considered provisional at best, so you will have to keep guessing which region is your home! In addition, before anyone gets too worried, these effects are dwarfed by the effect of severity of illness in the presenting patients (by a magnitude

of four times), which, if presented on the same figure, would make the regional differences almost too difficult to see.

Had I put the same figure up for 2005, you would have seen even greater differences between the regions. Although outcomes are now more uniform, this 2010 analysis still shows variation in patient outcomes depending on where the patient

is admitted to ICU. It is only through ongoing contribution to ANZICS CORE that findings such as these can be identified and investigated to know if they are real and then have causes determined.

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

PS Thanks to Michael Bailey for the statistical analysis.

## Safety and Quality Report



The Safety and Quality Committee continues to strive towards promoting, supporting and encouraging safety and quality in intensive care.

Progress is steadily being made on the Care of the Ventilated Patient Consensus Statement. A well-attended workshop conducted in August 2011 provided robust discussions and an opportunity to develop the recommendations. An online survey is being developed to determine the level of members' agreement with the statement. The Safety and Quality Committee thank Marghie Murgo for her ongoing assistance in writing this statement.

The Committee is working towards a position statement in relation to the safe and appropriate use of antimicrobials in hospitals. The Australian Commission on Safety and Quality in Health Care released

two documents: Antimicrobial Stewardship in Australian Hospitals (2011) and the National Safety and Quality Health Service Standards (June 2011). Both these documents highlight the increasing importance of antibiotic stewardship in the Australian health system.

The 5th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (SQAQO 2011) took place at the Crowne Plaza, Hunter Valley 1st – 3rd August, 2011. The stimulating program and enjoyable social events ensured the ongoing success of this annual meeting. For the first time this year seed funding was offered to promote a quality project in intensive care. The Safety and Quality Committee and Baxter were proud to offer the funds to Ravidranath Tiruvoipati to support his project titled 'Evaluation of clinical outcomes and cost consequences of delayed discharge from intensive care: a multicentre prospective observational'.

The ANZICS/ACCCN Annual Scientific Meeting also provided an exciting opportunity to showcase the ongoing work in safety and quality within intensive care. The Baxter prize for the Safety and Quality Best Paper was awarded to Claire Rickard and colleagues for their paper 'Peripheral intravenous catheters can be left in situ until clinically indicated for removal: randomised controlled trial'.

The Committee has amended its Terms of Reference, which are now available for download from the ANZICS website: <http://www.anzics.com.au/safety-quality>. As a result of the amended Terms of Reference the Committee is in the process of being reformed. The next Committee meeting will be held in November 2011.

For further information regarding the ongoing work of the Safety and Quality Committee please feel free to contact [Jennifer.Holmes@anzics.com.au](mailto:Jennifer.Holmes@anzics.com.au).

**Tony Burrell**  
**Chair, Safety and Quality**



# ANZICS

**Advocate for Intensive Care  
throughout Australia & New Zealand**

**[www.anzics.com.au](http://www.anzics.com.au)**

# ANZICS CLABSI Prevention Project

This project commenced in March 2010 and its objectives are to:

1. Decrease the rate of CLABSI in Australian ICUs to <math><1/1000</math> 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 much slower than predicted, however strategies to achieve objective one should be launched in at least three states in November/December.

## CLABSI Definition

The Project Manager has worked with an ACSQHC committee to establish a 'national' CLABSI definition (see link) and the implementation document should be ratified and put out for consultation at the end of October. This work is important as all jurisdictions will be requested to use the same surveillance definition and to undertake CLABSI surveillance in ICU, thereby providing a method of evaluating the effectiveness of the project. <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 almost finished development of the national CLABSI 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.

**Gabrielle Hanlon**  
**CLABSI Project Manager**  
[Gabrielle.hanlon@anzics.com.au](mailto:Gabrielle.hanlon@anzics.com.au)

# Paediatric Report



This will be my last report for *The Intensivist* as I will be handing over the Paediatric Chair position on the ANZICS Board in the next

few weeks in order to devote more time to the Paediatric Study Group of ANZICS. I have been on the ANZICS Board since the last Hobart ASM and have thoroughly enjoyed my time on the Board. I would like to thank all the Board members who have worked with me during my time on the Board, in particular the Presidents - Ian Jenkins, Peter Hicks, Michael O'Leary and Mary White (it's been a long time), as well as Erin O'Sullivan and Alana Lakeland for their hard work.

ANZICS' role in overseeing its exceptionally performing components, the CTG and CORE in particular, remains critical. It is important that intensivists feel represented and feel a sense of ownership of these components of ANZICS.

Despite a relative deficiency in membership among paediatric

intensivists (this is a hint!), ANZICS has an important role to play in paediatric intensive care and I think this is reflected in the strong interest in the paediatric position on the Board and I would like to wish my successor well.

## Paediatric Study Group

The Paediatric Study Group had a face-to-face meeting prior to the Brisbane ASM. All paediatric units were represented.

## Current Studies

### Brain Injury Studies

John Beca is currently analysing the results of the HITBIC study and preliminary results were presented at the Brisbane ASM. The Cool Kids trial, which the PSG participated in, was stopped earlier this year on the grounds of futility following an interim analysis (for the primary outcome, mortality). The patients recruited will be followed up and analysed for secondary outcomes (neurological performance).

There are a number of other trials in development, including Serum

Biomarkers in Traumatic Brain Injury and Early Decompressive Craniectomy in TBI.

## Safe-EPIC Proposal

The point prevalence day on saline/fluids was held on 21st September and included paediatric units. Marino Festa is the Principle Investigator and will perform statistical analysis on this work (as well as the previous point prevalence day), with the aim to eventually stage an international point prevalence study next year. The paediatric units hope to be involved in all future point prevalence days where feasible.

## CLOTS Study

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 SA Women's and Children's Hospital Foundation. Michael Yung is the Principle Investigator. The study is currently recruiting at the three centres with the imminent addition of two more centres.

## **SPICE (Sedation Practices in ICU)**

The paediatric units are meeting with the SPICE Committee and this will be the first combined adult/paediatric CTG study. An NHMRC grant application is currently being finalised.

## **Adrenaline/Steroids in Acute Bronchiolitis**

Grant application for multicentre RCT. The Principle Investigator is Warwick Butt.

## **ANZPIC Registry**

The 2010 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 were presented at the Brisbane ASM.

## **Brisbane ASM**

The scientific program for the Brisbane ASM was very well received. Congratulations go to the paediatric convenors Kevin Plumpton, Christian Stocker and Debbie Long. International speakers were Peter Weinstock, Director of the simulation program at the Children's Hospital, Boston and 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, albeit 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 Chair, Paediatrics**

## **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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# PricE Committee Report



The PricE Committee, which is charged with advocating on industrial issues and matters pertaining to intensivists'

remuneration, especially in Australia in the private sector, continues to be active on several fronts. One area, however, where I feel we need to increase our efforts is in the area of medical workforce in intensive care medicine.

The Australian population continues to grow, both naturally and from net inward migration. More importantly for us it is also aging, with the baby-boomer bulge now starting to push into the most popular age for ICU admission - 70-80 years of age. It seems that expectations by both the public and some of our colleagues of the outcome from an intensive care admission for a gravely ill or terminal individual continue to outstrip reality, although data for this last assertion are lacking. Certainly admission rates per capita for the elderly are increasing

– there is readily available data to support this in the private sector at least.

Against this backdrop of burgeoning demand there is the lag of state governments in Australia to construct and fund either bigger or more hospitals and, in particular, more or bigger ICUs. With an annual recurrent budget of some \$1.5 million per ICU bed in a Level III, this is hardly surprising. Limiting bed numbers caps supply of ICU services and ultimately enforces rationing. Traditionally, at senior level at least, most workforce modelling links staff to funded beds, with an oft quoted figure of four full-time equivalents (FTE) per pod of 10-12 beds. As ICUs become more crowded and with higher acuity patients it is moot as to whether some other metric, such as admissions, bed days or ventilated hours per intensivist, may be a more useful metric by which to compare work practices.

Intensive care training stands out against many other specialties - there is almost no restriction on the number of trainees – there are jobs aplenty

and, unlike most other specialties, we are not reliant on international medical graduates (IMGs) to fill many registrar positions. This situation varies widely from state to state - in Western Australia, where medical student numbers have increased rapidly and significantly, there is now a wave of young local graduates progressing through their junior years. IMGs who may prefer to (re)train in a different specialty in Australia or New Zealand, such as anaesthesia, may sometimes turn to ICU when they find no available training positions in other specialties.

With the large number of graduands admitted to Fellowship of CICM in the last decade we are a relatively young specialty - it is likely that there will be a significant net increase in the number of Fellows annually, as the number entering Fellowship exceeds those changing careers, retiring, dying or reducing working hours.

Our roles within hospitals (and without) is still evolving, particularly in relation to MET teams, provision of parenteral nutrition, teaching of life support and resuscitation skills,

in administration, management and planning.

Against this backdrop Health Workforce Australia, a statutory body of the Commonwealth, has commenced work in an attempt to quantify the number of medical specialists required over the next two decades, including in intensive care. Nick Edwards recently represented ANZICS at a HWA meeting convened in Adelaide. Clearly modelling of workforce is dependent on the robustness and validity of the input

information – it was apparent that HWA's data were clearly flawed.

Intensive care is unlike many specialties in that it can only be practised in hospitals and even then, only larger, more sophisticated hospitals. By and large, most of us work with a predominant public component. Both the spectre of undersupply of intensivists, with the limited pool of clinicians overworked, burning out and rationing resources, and oversupply, with unemployed or under-employed trained specialists,

who by dint of their numbers reduce any industrial or strategic gains of their predecessors, are unpleasant and unwanted prospects. No one wants to see doctors vigorously pursue a career in intensive care, with the rigorous training and tough hours involved, only to be unemployed on reaching Fellowship. We need to model as best we can demand and supply and develop innovative ways to match the two.

**Ian Jenkins**  
**Chair, PricE**

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## Education Committee Report

ANZICS recently established an Education Committee to provide advice to the Board on the priorities and direction of our professional education and training.

One of the first initiatives of the new Committee is a stocktake of professional development opportunities for members of the Society and colleagues working in intensive care. The aim of this study is to provide an assessment of our professional development needs and the extent to which those needs are being met, as well as make recommendations around possible alternative forms of delivery that take account of the geographic spread, size of professional cluster and availability of professionals in intensive care.

We are also keen to establish an understanding of the expectations that members have of the Society in relation to education and training. This element of the project will occur in its later stages early next year. Over the next 3-4 months we will be asking you to help us better understand your needs and priorities by being an active part of our consultation on these issues. In our efforts to be inclusive and thorough you may be consulted more than once but we ask for your patience and support.

At the ASM the consultant assisting the Committee with the project,

Bonita Mersiades, conducted one-on-one 'snap surveys' with 188 delegates comprising doctors, nurses and allied health professionals. Of the respondents 85% rated the ASM as a minimum as 'important' in meeting CPD requirements. Almost 81% of respondents attended with colleagues. According to 51% of respondents the main reason for attending was to get an update/professional development purposes, with 36% nominating the networking opportunities.

Shortly we will be sending out an online survey to attendees seeking more details specifically regarding the ASM. Towards the end of January next year we will be writing to all members of the profession asking them to complete a more detailed online survey seeking input and feedback on matters such as preferred style, timing and delivery mode of professional education.

In the interim period we will be working with ANZICS Regional Committee Chairs and Education Committee members via the network of ANZICS LinkPersons at sites across the two countries to begin capturing current education and training activities.

I hope that you are able to spare the time to give us your views on this important subject for all of us as individual professionals, as well as the community we serve.

If you have any questions or wish to discuss this work, please do not hesitate to talk with me or other members of the Education Committee in your region, who are listed on the ANZICS website at [www.anzics.com.au/committees/education/239-education-committee-membership](http://www.anzics.com.au/committees/education/239-education-committee-membership)

Alternatively, you can also contact Bonita at [bonitamersiades@gmail.com](mailto:bonitamersiades@gmail.com) or 0416 071 000.

**Gerry O'Callaghan**  
**Chair, Education Committee**

### Committee Membership

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





# 2012

6th International Conference on  
**Safety Quality Audit & Outcomes**  
Research in Intensive Care  
Melbourne, Australia  
23 - 25 July, 2012



The 6th International Conference on Safety, Quality, Audit & Outcomes Research in Intensive Care (SQAO 2012) will continue to explore the four domains of Quality - Structure, Process, Outcomes and Culture. The conference is suitable for both clinicians and researchers and will feature interactive sessions and open discussion with an emphasis on everyday care.

[www.anzics.com.au](http://www.anzics.com.au)  
Visit our website for further information



# Intensive Care Foundation

...we save lives



Thank you to all those who visited our exhibitor's booth at the ANZICS/ACCCN Annual Scientific Meeting which was held in Brisbane on 13-15th October this year.

Those who visited our booth would have enjoyed a cool Nudie juice while viewing our new YouTube clips.

**Congratulations are extended to all the Research Grant recipients this year and they are:**

Year	Project	Chief Investigator	Funds
2012	TEAM: Trial of early activity and mobility in ICU (Alfred Hospital, VIC)	Dr Carol Hodgson	\$45,000
2012	Early intervention to prevent muscle weakness in intensive care: a pilot randomised controlled trial (Austin Hospital, VIC)	Dr Sue Berney	\$40,000
2012	Prevention of Ventilator Associated Pneumonia by Inhaled Heparin (IPHIVAP) (Royal Brisbane and Women's Hospital, QLD)	Associate Professor Rob Boots	\$35,000
2012	A prospective, observational study of critical illness related changes in bone mineral density, bone turnover and calcium metabolism (Barwon Health, VIC)	Dr Neil Orford	\$28,000
2012	Do thromboelastometric parameters change with increasing degree of sepsis related organ failure? (Flinders Medical Centre, SA)	Dr Shivesh Prakash	\$12,000
2012	Disposition of sedative, analgesic and antibiotic drugs during simulated extracorporeal membrane oxygenation (Prince Charles Hospital, QLD)	Dr Kiran Shekar	\$12,000
2012	Effect of ECMO on long term disability in severe ARDS (Alfred Hospital, VIC)	Dr Vincent Pellegrino	\$10,000
2012	Post Resuscitation fluid boluses In severe sepsis or septic shoCk prevalence and Efficacy (PRICE study) (Flinders Medical Centre, SA)	Dr Shailesh Bihari	\$7,000
2012	Mike Cowdroy Rural Nurses Education ICF Grant	Julie Greaves	\$907
			<b>\$189,907</b>

We encourage you to get involved by visiting our website, like us on our Facebook page, watch us on YouTube and keep up to date on Twitter.

EUROPEAN SOCIETY  
OF INTENSIVE CARE  
MEDICINE



## Dual Membership Offer

Join ESICM for only € 100 if you are already a member of a cooperating society.

The ESICM is entering into partnerships with the National Societies of Intensive Care in order to provide increased benefits to both societies' members.

**For € 100, you get the following membership benefits:**

- Access to the online version of the journal **Intensive Care Medicine** (paper version: optional upgrade fee)
- Access to **PACT** web-based learning programme
- Access to all **Flash conferences**, podcasts and e-posters on the ESICM web site
- Discounted rates to **EDIC** board exams, to the ESICM Annual Congress and to all meetings endorsed by the ESICM
- Access to ESICM electronic newsletter
- Ability to join **ESPNIC** (optional upgrade fee)

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# Intensivist

By joining the Friendly Society Private Hospital you can have the career and the lifestyle!

Intensive care medicine covers the assessment, resuscitation and ongoing management of critically ill patients with life-threatening single or multiple organ system failure. The Intensivist is an intensive care specialist who assists with the management of seriously ill patients.

The Friendly Society Private Hospital is expanding its coronary care unit to include Intensive / Critical Care. A vacancy exists as an Intensivist for this new service being delivered to the Bundaberg community. The role would work alongside other key visit medical specialists and be supported by a team of critical care nurses.

This position requires the applicant to be a fellow of the College of Intensive Care Medicine (FCICM). An attractive salary package will be provided in accordance with the candidate's experience and qualifications.

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Further information about these positions please contact Yvonne McChesney on +61 7 4153 0709 or via email [hr@fsph.org.au](mailto:hr@fsph.org.au) or to apply please email [hr@fsph.org.au](mailto:hr@fsph.org.au) by including a resume and covering letter that outlines your skills, abilities and experience. Applications can also be submitted online via [www.fsph.org.au](http://www.fsph.org.au).



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## Senior Medical Officers – ICU

By joining the Friendly Society Private Hospital you can have the career and the lifestyle!

An opportunity for highly skilled medical professionals has arisen in our recently expanded nine bed critical care unit. Join a dynamic and progressive private hospital located in regional Queensland that boasts modern, state of the facilities and technology which has recently opened a multi-million dollar redevelopment.

The successful applicants will become part of a leading team that provides exceptional care for our regional community. This role will interact closely with consultants and nursing staff to maintain the highest of standards and will be well supported by on-site and on-call consultants. You must hold the appropriate medical registration and possess an understanding of private medical services, have post graduate experience in anaesthetics/air way management and emergency response.

A flexible roster and an attractive salary package will be provided in accordance with the candidate's experience and circumstances.

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Further information about these positions please contact Yvonne McChesney on +61 7 4153 0709 or via email [hr@fsph.org.au](mailto:hr@fsph.org.au) or to apply please email [hr@fsph.org.au](mailto:hr@fsph.org.au) by including a resume and covering letter that outlines your skills, abilities and experience. Applications can also be submitted online via [www.fsph.org.au](http://www.fsph.org.au).



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