Status of national guidelines in dictating individual clinical practice and defining negligence

Letter 1

Editor—As the current chairman of the Safe Anaesthesia Liaison Group at the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland, and the National Patient Safety Agency, I should like to make the following observations on the editorial by Fearnley and colleagues.1

The editorial is a well-written discussion of the role that national clinical guidelines may play in the determination of negligence in clinical practice. The only example used is the guidance from NICE (Technology Appraisal Guidance Number 49) issued in 2002 which recommends that the use of two-dimensional imaging ultrasound guidance should be considered in most clinical circumstances where internal jugular central venous catheter (CVC) insertion is necessary either electively or in an emergency. The clinical case cited is of a fistula formed between the vertebral artery and the internal jugular vein.

This guidance has been the subject of considerable debate over the last 10 yr and several surveys have shown that the uptake of the guidance has been slow. From the two references quoted in the editorial, 66% of anaesthetists in the USA in 2007 never or almost never used ultrasound-guided CVC insertion and in 2008, only 27% of UK anaesthetists used it. The audit conducted by NICE in 2009 showed only 47% of anaesthetists used ultrasound-guided CVC insertion in theatres. Reasons given include the lack of a convincing evidence base and a well-argued desire to retain the skills required for the landmark technique. The authors do not provide any references to support the use of ultrasound guidance at all times.

Ultrasound-guided insertion should be encouraged, especially if the internal jugular vein is not prominent, but since ultrasound is not always available in all circumstances, a landmark technique needs to be learnt and assessed in the workplace and at national examinations.

The authors are of course entirely at liberty to express their view that ultrasound guidance should be used for all internal jugular cannulations. Unfortunately, to state that ‘in the case of the use of ultrasound during central venous catheter insertion by the jugular route, the evidence base is now so compelling that the authors would question whether in the event of complications of arterial cannulation during central venous access without using ultrasound, the issue is less a matter of financial compensation and more one of disregard for patient safety which merits the attention of the GMC, or criminal charges if the outcome of the complication is death’. While undoubtedly eye-catching (not least to the legal profession), it is an extreme and unsubstantiated opinion and should be withdrawn and revised to reflect both the intended role of clinical guidelines and the true position of ultrasound-guided CVC insertion in clinical practice.

Declaration of interest

None declared.

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Letter 2

Editor—In a time of increasing emphasis on national guidelines and reliance on medical technology to further clinical practice, we read with interest the editorial by Fearnley and colleagues1 on the status of national guidelines in dictating individual clinical practice and defining negligence. We do however feel that the editorial raised a number of controversial points.

NICE guidance 49 relating to the placement of central venous catheters has an evidence base that was the subject of considerable debate and adverse criticism after its publication.3 The studies that informed the guidance were limited by a number of methodological flaws.4

The authors are highly selective in their choice of evidence and we believe that this results in an unbalanced appraisal of the current literature and clinical practice. Two of the articles referenced demonstrate an incomplete transition to ultrasound (US) guidance becoming the norm. Sixty-seven per cent of American practitioners never or almost never use US, while only 27% of UK anaesthetists used US for their first attempt.5 6

The unstated implication of the text is that if one uses US, whatever happens, you are in the safety net. Yet identifying the vessel is only one aspect of cannulation: it is training and good practice with the total task that matters. In the wake of the guidance, we now have a generation of trainees that cannot correctly identify the anatomy. They practitioners may puncture the artery9 or damage the posterior wall of the vein even when using US guidance.9 A recent meta-analysis showed no difference in the rate of success

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