JRCALC, Resuscitation Guidelines and Updating Practice. September 2004.

This document outlines the recent European Resuscitation Council's Position Statement: Research on procedures in cardiopulmonary resuscitation that lie outside current guidelines (D. Chamberlain and Handley A.J. Resuscitation 60 (2004) 13-15) and summarises the JRCALC's initial response to this important statement. The matter is to be discussed by the full JRCALC Committee that next meets in November 2004.

Any significant advances in improving the outcome from cardiac arrest have remained disappointingly elusive over the past 25 years, and the only manner in which this can be improved will come from the instigation and investigation of new approaches. Furthermore, the evidence base for existing practice has never been so robust as the published guidelines might suggest. Findings are now emerging that challenge established practice and suggest a means by which more patients may be successfully resuscitated. These approaches include giving chest compressions before defibrillation, the use of vasopressin instead of the time-hallowed adrenaline and thrombolysis for defibrillation-resistant arrest.

The ERC "guidelines" that advise on the current management of cardiac arrest are drawn up by a process of international consensus, and the Joint Royal Colleges Ambulance Liaison Committee embraces these in its own. Whilst the worth of such consensus opinion cannot be underestimated, two disadvantages do arise. The first is that the principle international group that draws up the "Guidelines" (in this case ILCOR – the International Liaison Committee on Resuscitation) can only meet up in full session once every five years. Such a delay is an inevitable part of any formal guideline process (including the JRCALC's) with the result that any new advance may take some time to be incorporated. Although the issue of interim statements can to some extent offset this disadvantage it still remains a less than satisfactory method of facilitating timely changes in practice. The second disadvantage arises from the fact that the publication of international agreements on treatment guidelines tend to be regarded as cast in stone with the result that any subsequent changes may be regarded as contravening established "law". This may pose a particular problem for ethics committees seeking to protect the interests of those who, particularly in the field of cardiac arrest, may be unable to give informed consent.

It is of course imperative to protect the interest of the patient when any deviation from an established guideline is proposed, and to ensure this three conditions must be met. First, the proposed change in treatment (or deviation from the established guideline) should offer the real possibility of an improved outcome. Two, that this possibility should be sufficiently strong to create a situation of equipoise and three, that the need for any protocol deviation should be supported by a body of opinion that can command respect.

In the summary of its Position Statement the European Resuscitation Council has stated that *"…emerging evidence suggest that current international guidelines on basic and advanced life support probably require modification if survival from cardiac arrest is to improve"* and it's wish *"… to state its view that deviations from existing guidelines,* ***in the context of appropriately planned trials*****,** *is not only permissible but also highly desirable."* As representatives of JRCALC we fully endorse this statement and wholeheartedly support measures that might offer better patient survivability from the critical event of cardiac arrest, and support those ambulance trusts who are currently taking part in the audit of new protocols on resuscitation provided of course that they have the appropriate ethics approval and are supported by the RC(UK) or the ERC itself.

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