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Editorial

Challenging the status quo: Time to adopt the "80% sure" principle?

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One of the goals of this journal is to encourage vascular access clinicians and researchers to question current practice and consider alternative ways of providing vascular access care. In this issue, we feature an article on the use of large-bore peripheral intravenous catheters (PIVCs) in women giving birth.

Customary practice in many countries, including Australia, sees large-bore PIVCs placed in obstetric patients for the possibility that some will encounter a post-partum haemorrhage and need a blood transfusion. Examining data from the OMG study[1], the paper in this issue by Webster *et al*. reports that over 40% of women had a large bore (14 to 18 gauge) PIVC inserted, most often in the hand or wrist, with a phlebitis rate of 12%, compared to 7% for those with a smaller gauge catheter. Sixteen per cent of catheters were idle (no fluids or medications prescribed for the past 24 hours), and phlebitis rates for idle catheters were even higher (17%). In this study cohort, only 2% of patients received a blood transfusion on the day of the study. As this data comes from a prevalence study, the results cannot be taken as comprehensive, but they should nonetheless cause us to pause and consider current practice.

Cannulation is painful and time-consuming. It can lead to phlebitis and other complications, and repeated needlesticks can lead to needle phobia[2] and venous depletion[3]. It is time we asked patients about their own preferences[4]. And it is time we questioned the need for cannulation at all for some patients and, in particular, the use of 'just-in-case' large-bore devices. There is no question that insertion of a large-bore catheter is probably a wise choice if the patient is deemed high-risk. But the majority of obstetric patients are not high-risk, and with careful monitoring, there is time for measured decision-making in most cases. Perhaps it's time to embrace the "80% sure" criteria reported by Hawkins *et al*.[5]. Unless we're 80% sure the haemodynamically stable obstetric patient is likely to need a large-bore catheter, maybe we should pause and weigh the risks and benefits. I'd love to hear your thoughts.

After four years as Editor-in-Chief for *Vascular Access*, I will be stepping down to pursue other career directions, namely the amazing opportunity to spend three months with Dr Vineet Chopra and his team in Michigan, progressing the I-DECIDED® IV assessment tool[6]. I would like to thank the AVAS editorial board for your strong support and generosity in reviewing articles during my tenure as Editor-in-Chief. We are now seeking expressions of interest from those interested in trying their hand at the editorial role. Mentoring and support will be provided until you find your feet. With only two issues per year, it's not a big commitment and provides an extremely interesting and useful perspective on peer reviewing and publishing, as well as a marvellous addition to your CV. I encourage you to consider if this might be the next step in your research career.

Gillian

Gillian Ray-Barruel
Editor-in-Chief, *Vascular Access*

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President's message
Seeing with new eyes and a fresh perspective

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The real voyage of discovery consists not in seeking new landscapes, but in having new eyes.

The above sentence is a paraphrase of Marcel Proust's lengthier musings on art, but I believe it is relevant to us as clinicians and researchers. In order for us to move forward in our research, education and practice, we need to be open to new ideas and be prepared to view our patients, clinical setting, and problems with new eyes, a fresh perspective.

We cannot solve our problems with the same thinking we used when we created them ... if you will indulge me in a second quote (this time from Albert Einstein).

I am personally in the perfect setting as I write this column since I am at my first (though actually the final) SMACC* conference in Sydney. This conference disrupted the professional meeting space at its launch in 2013, and continued to challenge the way we impart clinical skills and knowledge.

SMACC* began as a physical manifestation of an online community, united in their vision of creating high-quality, free, open-access medical education (FOAMed) for the prehospital, emergency, and critical care community. The driving force behind SMACC has always been to educate, inspire, innovate, and connect delegates.

In its own small way, the AVAS community also hopes to inspire and educate, and I hope you will join me and many others (bring a friend) at the upcoming AVAS Scientific Meeting in Sydney this May. www.avassm.org

The true challenge comes when we return home and consider what impact our new learnings have on our clinical research, education and, of course, patient care. It is the left-field perspective that fuelled the authors of the lead publication to question and examine the merit of routine insertion of large-bore catheters in obstetric patients. I encourage you to read this and the accompanying editorial and consider what other routine vascular access practices require review and a fresh perspective.

In that vein (pardon the pun), it is time for AVAS to invite fresh eyes to the board and elect a new team to guide the Society over the next two years. It is an exciting time to be in the emerging speciality of vascular access in Australia. We are poised to assist the Australian Commission on Safety and Quality and Health Care to develop a national standard for peripheral IV insertion and care, and health care itself is on the verge of significant change, as the medical model, as we know it, is no longer sustainable, and a more multidisciplinary, team-based approach to health care emerges. I hope the leaders and potential leaders in vascular access step forward to be part of a new administration with a fresh vision, promoting safety and excellence in vascular access, and health care more generally.

Best wishes,

Sam

Samantha Keogh
AVAS President

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