Hickie's statement "in my experience the unfortunate outcome can usually be predicted within reading the first few paragraphs of the brief" epitomises the very problem we address. Such retrospective snap judgements are characteristic of hindsight bias and are often accompanied by the telltale phrase, known to be a marker for hindsight bias,[1] "it should have been obvious".

We are unable to understand Hickie's statement that our "views . . . might have been slightly biased on the basis of . . . cases . . . reviewed as Chairmen of the Australian Cases Committee of the Medical Defence Union". The Committee contained representatives from the major specialties, including two consultant physicians, and the cases ranged over all specialties and subspecialties. Experts from subspecialties, including cardiology, were co-opted when appropriate.

We agree with Hickie that clinical practice guidelines are useful. We did not recommend that they be excluded, but we did draw attention to their difficulties and limitations.

We acknowledge the admirable work done by the American College of Cardiology in developing an impressive range of guidelines, but our view remains unaltered that they are costly in terms of time and effort to produce, cannot cover all clinical contingencies, and have limitations when applied to negligence cases. The guidelines for heart failure referred to by Hickie took more than three years to prepare, involved numerous committee members and no fewer than 26 reviewers, and were not subsequently updated for six years. Relatively few guidelines have been modified for Australian use and some are obviously deficient. For example, the current National Health and Medical Research Council (NHMRC) guidelines relating to the common problem of chest pain[2] are six years old, and have been criticised on the grounds that they have not been rigorously tested to ensure clinical usefulness and do not include appropriate management strategies for patients with non-cardiac chest pain.[3]

We adhere to our view that these problems make it likely that clinical practice guidelines will have a limited role in negligence cases.

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snapshot

Fatalities from bread tag ingestion

PLASTIC BREAD CLIPS are a rare but potentially avoidable cause of gastrointestinal obstruction or perforation which can be fatal.

Case 1: A 79-year-old woman presented with peritonitis thought to be the result of a perforated viscus. Her condition was too poor for immediate operative intervention, and despite supportive treatment she died the same day. At autopsy, ileal perforation was identified related to a firmly adherent plastic bread tag (Figure). Two adjacent foci of congestion and mucosal distortion 24 cm proximally suggested a prior clip attachment site. She had suffered from dementia and her meals were made by her husband, who was blind.

Case 2: An edentulous 82-year-old woman presented with a one-day history of abdominal pain. A laparotomy showed ileal perforation related to a bread tag attached to the mucosa. Postoperatively, she developed bronchopneumonia which proved fatal. Three months before presentation, she had suffered a less severe episode of abdominal pain which had resolved on conservative treatment from her general practitioner.

In Australia most bread bags are sealed by hard plastic clips. These are cheap and convenient, enabling the bag to be resealed after use. However, some countries have withdrawn their use because of gastrointestinal problems after ingestion.[1,2]

Patients swallowing clips are typically elderly and edentulous. The clips tend to snag on the small bowel mucosa, which may obstruct, erode or perforate. Impaction in the oesophagus, stomach or colon has also been reported.[3] The tags are generally not seen on plain x-ray[2] and patients are often unaware that they have swallowed them. Because of the high risk of complications, early endoscopic removal is advocated.[4] With an ageing population, the proportion of edentulous people is likely to rise, increasing the risk of foreign-body ingestion.

Alternative plastic bag sealers are available, although some also present health hazards. For example, ileal perforation has been reported after swallowing a freezer bag tie containing a wire.[5]

Bread bag clips have recently been replaced with tape in the United Kingdom for safety reasons (A Bennett, Allied Bakeries Customer Services Representative, Allied Technical Centre, Maidenhead, Berkshire, UK, personal communication). Abandoning the use of hard plastic bread tags in Australia in favour of adhesive tape would counter this health hazard.

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Bread tag from the patient in Case 1, detached to reveal the site of ileal perforation. Scale is in centimetres.

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