

**Editorial**

## Developing Emergency Medicine Clinical Practice Guidelines in Pakistan – a pressing priority

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Over the last couple of decades, clinical practice has rapidly shifted towards evidence-based medicine (EBM). One of the primary outcomes of EBM is clinical practice guidelines (CPGs).<sup>(1)</sup> CPGs are 'systematically developed statements to assist practitioner decisions about appropriate health care for specific clinical circumstances'.<sup>(2)</sup> Although the first CPGs can be traced back to the late 1970s<sup>(3)</sup>, they have only become an integral part of good medical practice in recent years. In emergency medicine (EM), ACEP has published guidelines since the 1990s<sup>(4)</sup>, while RCEM and ACEM have recently joined these efforts.

The primary goal of CPGs<sup>(4,5)</sup> is to provide the best possible care to patients in the shortest possible time. The scope of CPGs in EM extends well beyond initial patient care. They improve quality of care and life, positively impacting health outcomes, thus reducing mortality and morbidity.<sup>(5,6)</sup> CPGs also help ensure delivery of uniform care<sup>(5,6)</sup> to patients, regardless of socio-economic status, gender, religious beliefs, or cultural differences. They discourage unnecessary investigations and encourage timely management and intervention. CPGs empower the healthcare provider by promoting passive learning, encouraging better clinical decision-making, and acting as a reference standard for good medical practice. They are an essential tool for clinical governance. The overall impact of appropriately designed and correctly implemented CPGs is a robust, safer, reliable, cost-efficient, and productive healthcare system.<sup>(7)</sup>

In Pakistan and many other countries across the sub-continent, EM is a budding specialty with very few well-established independent emergency departments (EDs) and trained EM physicians. Physicians are still running most EDs from various subspecialties, whose EM practice is influenced by their areas of expertise and years of experience. This culture results in a significant variation in managing acutely unwell patients presenting to the ED. Furthermore, the designated 'casualty medical officers' tend to refer and transfer patients to other specialties as soon as possible. The main driving force for such practice is lack of training, a knowledge gap, and lack of ownership.

Such conventional practices result in delayed diagnosis and/or treatment initiation, and the patients are often ping-ponged between physicians and specialties. The consequence is a growing disharmony between the public and EM physicians. There is often aggression from the frustrated patients and their families, while the healthcare providers resort to strikes. As this lack of trust and frustration increases, the patient's confidence in the ED system sinks low, while the clinicians become increasingly reluctant to work in such hostile conditions. Thus, a never-ending vicious circle persists between the agitated patient and the demoralized EM physician. CPGs can help address this vexatious situation by reducing such inconsistencies in medical practice and ensuring transparency and clinical governance.

Finally, while there is an abundance of EM CPGs on various international forums, it is vital to develop our national guidelines, or modify the existing ones, according to national needs and available resources to optimize acceptability and promote implementation.

In conclusion, this article has highlighted the call for developing and implementing CPGs as the need of the hour to revamp national EM practices. They will help standardize and raise the quality of patient care and reduce the trust gap between the public and the EM healthcare system.

### REFERENCES

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