

The importance of clinical pathways in daily clinical practice

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"Medical care is based on tradition, on the skills learned and on experience. As such, patients with the same conditions are treated differently, by different physicians and with different outcomes¹". With these words, Audimoolan et al justified the variability of medical decision, whilst pointing out the underlying cause in an implicit and intuitive way. There is indeed a wealth of literature on the variations in clinical practice and the sources thereof²⁻⁵. Specifically, the degree of uncertainty (absence of scientific evidence to resolve a specific clinical problem), ignorance (scientific evidence exists but this is either not known or is out of date), external pressure (the physician is aware of the scientific evidence but elects to follow a different course), the lack of resources (unavailability of complementary explorations or required treatment) and the patient's own preferences (rejecting or accepting the evidence) have been identified as the source of the differences in clinical decision-making for individual patients. In order to mitigate such a situation, the different health centres, scientific societies and those responsible for healthcare policy are committed to making recommendations based on evidence⁶. The need to have solutions that respond to real clinical problems in a simple, suitable, valid, accurate, and easily understandable way at patient care points led to the creation of the clinical practice guidelines (CPG)⁷. The Institute of Medicine proposal of 1990 thus defined CPG as the set of recommendations that have been systematically developed to assist physicians and patients in the decision-making process, to select the most suitable interventions to resolve a

clinical problem under given healthcare circumstances⁸. These can easily be viewed as costly and lengthy to develop and that, in the absence of sufficient quality scientific proof, may not yield a suitable response in daily clinical practice. For this reason, clinical pathways (CP) have gained popularity in recent years. CPs can be deemed to be the operative version of the CPG: whereas the latter defines the care that must be given to a patient, the CP defines when, how and in what sequence such care must be provided⁹⁻¹³. CPs therefore consist of medical care plans applied to patients with a particular condition and that present a predictable clinical course, defining sequence, duration and optimum responsibility for the activities of the physicians, nursing staff, patients and other professionals, reducing delays, improving the use of resources and maximising care quality⁹. In order for the investment of time, resources and effort to be worthwhile, the CP must match a specific and well-defined condition with a considerable frequency or else of high social and economic impact or high morbidity-mortality, with an unexplained variability in terms of treatment. Once the specific condition has been defined in accordance with the abovementioned characteristics, that is to be the subject of a CP, the various stages must be identified. To this end, the FOCUS-PDCA¹⁴ model is generally used, consisting of the following stages: choice of medical procedure, condition or activity; bibliographic review of the subject; creation of a multidisciplinary team responsible for the development of the CP; CP design and matrix thereof; performance of a trial run and preliminary analysis of

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results; CP adjustment and review; and final implementation.

In this issue of *Emergencias*, García-Castrillo et al¹⁵ illustrate and define what has been discussed so far in the CP for infection of the varicella-zoster virus (VZV). How it was detected and what prompted the demand for the development of this CP, as well as the inception and design thereof have been covered. A further step was taken with the trial run prior to the adjustment and review that precede final implementation, and it is worth mentioning that the number of conclusions arrived at has been significant. Firstly, the authors have identified a lower than expected incidence of VZV infection in hospital emergency departments (HED). Although deficiencies in registration can partly explain this discrepancy, there is also another possibility based on the inherent characteristics of the condition in question. The real incidence of VZV infection in HEDs may indeed be lower than that inferred in the initial stages of CP development, which would reflect negatively on this decision given that it is a clinical problem with a minimal numerical impact. The inclusion of other areas in addition to HEDs, such as primary care centres, continuous treatment centres, paediatricians and medical emergency services in the target population would probably help to correct this divergence¹⁶. Despite this observation, the authors arrive at a second significant conclusion: the severity and percentage of admissions among VZV affected patients are higher than expected. Consequently, and thanks to the trial run, the researchers observed that VZV infection has an acknowledged morbidity with the ensuing social and economic impact that, in and by itself, justifies the CP. Moreover, to further support its development, a high variability in the diagnostic and therapeutic management of this condition was identified. In summary, despite not being the aim of the work, direct and indirect signs and observations were detected to give clinical sense to the existence of a CP.

Thirdly, the degree of CP follow-up is analysed. In this regard, a high degree of compliance with treatment recommendations and information is observed, whereas the opposite is the case with recommended complementary explorations and ideal patient location. This finding is logical given the current conditions of HEDs. Adherence to a specific treatment depends, beyond possible external commercial factors, on the will to do so and the emergency physician who, in his search for clear and accurate clinical information, will undoubtedly follow it if it is available. This also ex-

plains the high degree of acceptance of a VZV infection CP among professionals. Unfortunately, ideal patient location is another matter. The almost permanent state of overcrowding must be added to the specific characteristics, size and location of each HED, the existence or not of observation areas therein, patient seats, short stay units and so on all of which hinder and complicate compliance with such recommendations¹⁷⁻²¹. As to the low rate of compliance regarding complementary tests, the authors suggest that day-to-day evidence should trigger a modification of the CP recommendations, which was indeed the main goal thereof. Thanks to the trial run, which in any case is required for the development and implementation of a CP, the authors gather enough useful information to move on to a further step: the adjustment and review of the CP, eventually leading to final implementation.

As head of the Office of Clinical Pathways and Guidelines of our society I would like, beyond the scope of the study by García-Castrillo et al, to acknowledge the enormous efforts made in the development and implementation of a CP which we have attempted to summarise herein. In a setting with excess data and growing clinical complexity, CPs should be the source of useful knowledge and experience to help make good decision-making at times of uncertainty. The clear objective of this office is undoubtedly to acknowledge, encourage, collaborate and support these initiatives which, in turn, will lead to a more equitable, effective, efficient, and better quality medical attention for all our patients.

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