Editorial

Better analyze the determinants of therapeutic inertia to overcome it

*Mieux analyser les déterminants de l’inertie thérapeutique pour les corriger*

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Chronic disorders have become frequent in medical practice in particular in general practice. Developing countries are also concerned by this phenomenon [1]. Indeed, pathological conditions such as cardiovascular disease, metabolic disorders, obesity, diabetes, cancer and AIDS, have become, thanks to therapeutic developments, diseases with a chronic dimension in that they never cease to worsen [2]. In face of this relentless progression and a medical profession that struggles to cope, we need to take responsibility for greater efficiency of care, for limiting the cost of healthcare, and for treating fairly those patients who are the most socioeconomically vulnerable or who are elderly. It falls to practitioners, and especially those in primary care, to practise medicine according to what Evidence Based Medicine has taught us over the past three decades [3].

Although these recommendations for good practice have been decreed, putting them into practice has come up against a number of problems. Two have been described in particular: inadequate compliance to treatment among patients and clinical inertia among practitioners [4]. The latter can be described as insufficient surveillance and treatment, despite the fact that recommendations have been widely disseminated, are well known and can easily be put into practice [5]. Clinical inertia can delay diagnosis and/or treatment, and put the health of the patient at risk. In the fields of cardiovascular disease, arterial hypertension, dyslipidaemias and diabetes, clinical inertia has been reported in a number of countries [6].

This issue of *Diabetes & Metabolism* presents various aspects of clinical inertia and in particular, brings together original and valuable information relevant to Europe and to France in particular. The studies presented have assessed the frequency of therapeutic inertia in the management of type 2 diabetes, and the characteristics of both the patients and physicians. They have also analyzed the reasons behind certain medical practices. Practitioner’s passivity in the face of chronic illness is sometimes considered to be lassitude or a lack of training or competence [7,8]. However, for some practitioners, the reasons are of an altogether different nature. Their attitude may in fact reflect a careful analysis of the patient’s situation, that only appears to be inertia and the physician is not culpable. The practitioner may consider that for a given patient or at a given time, the treatment recommendations are not applicable because of the patient’s age, physical or psychological frailty, socio-cultural barriers, lack of motivation, the patient’s depressed state, the coexistence of other pathologies or other situations too complex to be managed on their own [9]. Thus it may not necessarily be inertia in the follow-up or treatment, but a deliberate and justified decision not to intensify treatment. The facts reported in the various articles in this issue can help us to distinguish true and unjustified inertia from medical practices that have been somewhat modified, thereby seemingly not conforming to the current recommendations [10,11]. Also, it sometimes happens that the findings of meta-analyses and the often-revised guidelines are contradictory, thereby causing primary-care physicians to reject the opinions of experts and medical practices that are too restricted by guidelines [8]. Furthermore, many practitioners believe that the healthcare system is not properly organized to help them to manage patients with chronic disorders, who are becoming more and more numerous. The contributions of nurses and other healthcare workers, therapeutic education, healthcare networks, disease management and computerization have demonstrated their efficiency in the management of a
number of chronic illnesses [12-14]. The nuances between true inertia and involuntary inertia are important, and the data reported in this issue can help us to better distinguish between the two, and to bring concrete solutions in the face of this pandemic of chronic diseases. Nevertheless, clinical inertia and in particular therapeutic inertia in the management of chronic disorders such as type 2 diabetes are real, and should be identified and corrected [15,16]. Changes to oral treatments such as the initiation of insulin are notably inadequate. Indeed, the intensification of treatment, sometimes avoided because of the fear of adverse side-effects, is nowadays facilitated by the wide diversity of products at our disposal [17,18], and allow for much greater individualization of treatments, known to be a determining factor in the battle against therapeutic inertia.

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