Clinical inertia: viewpoints of general practitioners and diabetologists

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Abstract

Large clinical studies have enabled best practice guidelines to be issued. Intended to serve practitioners in their daily practice, the guidelines are also excellent tools for assessing physician performance. It was therefore demonstrated that despite the observation of insufficient glycaemic control, physicians did not systematically increase drug treatments. As a result, they have been accused of clinical inertia! In this journal, we first try to reveal what is behind this concept and to differentiate true inertia from pseudo inertia. Secondly, we consider how general practitioners and diabetologists, through their respective positions, can develop a synergy that is able to fight against inertia but that can especially, improve the glycaemic control of our patients.

Keywords: Clinical inertia; Diabetologists; General practitioners; Review

Résumé

Regards croisés médecin généraliste/diabétologues

Les grandes études cliniques ont permis l’émergence des recommandations de bonne pratique. Destinées à guider les praticiens dans leur pratique au quotidien, elles constituent également un merveilleux outil pour évaluer la performance des médecins. Il a alors pu être mis en évidence que malgré la constatation d’un équilibre glycémique insuffisant, les médecins n’augmentaient pas systématiquement les traitements médicamenteux. Ils ont été taxés d’inertie clinique! Dans cette revue, nous essayons dans un premier temps de percer ce qui se cache derrière ce concept et de différencier l’inertie vraie des pseudos inerties. Dans une deuxième partie, nous envisageons comment à travers leurs positions respectives, médecins généralistes et diabétologues peuvent développer une synergie qui permettra de lutter contre l’inertie mais surtout d’améliorer l’équilibre glycémique de nos patients.

Mots clés : Inertie clinique ; Diabétologues ; Médecins généralistes ; Revue générale

Chronic diseases are the health challenge of the 21st century. Their consequences are considerable, both in direct costs due to the consumption of care, and in indirect costs from loss of work days. Faced with our current inability to prevent these diseases, which are largely conditioned by our environment, it becomes essential to organize their care as best as possible in order to limit the consequences on the health of the populations, as well as their economic repercussions.

Besides cardiovascular disease, chronic respiratory disease and cancer, diabetes is recognized by the World Health Organization (WHO) as one of the 4 main chronic diseases [1]. Its management consists first of all in the control of risk factors, blood glucose, blood pressure and lipids, which are intermediary markers of the risk of complications. Immediately apparent is the specificity of this asymptomatic disease, which requires multifactorial management and often multiple medications, the objective of which is to minimize the risk of complications. The long-term maintenance of glycaemic control itself usually entails treatment escalation, which, besides dietary recommendations and physical activity, requires the addition of 2 to 3 classes of oral antidiabetic drugs, and then usually insulin therapy of up to 4 injections per day. The care recommendations for diabetes advocate early screening and management at a time when the patient is...
asymptomatic. On a daily basis therefore, no direct benefit of treatment is derived, while there are constraints and frustrations related to the dietary/lifestyle rules and the potential side effects of drug treatment, e.g., GI disorders with metformin, or hypoglycaemia with the sulfonylureas. To adhere to the treatment, or be observant or compliant (each person will choose the suitable term for themselves) is therefore to accept the constraints of the present in hopes of preserving the future. This requires that the patient have good understanding of the complex details of the management and an ability to envision himself in the future.

Since the results of the UPKPDS (United Kingdom Prospective Diabetes Study), which were published over 10 years ago now, the relevance of intensive glycaemic control in the prevention of microvascular complications has been considered beneficial by the entire medical community, foremost by diabetologists [2]. From the macrovascular point of view, the relevance of glycaemic control is much more uncertain, without counting the risk of an abnormally high death rate in high-risk patients [3]. Based on the results of large studies, best practice guidelines were established by many scientific societies and/or agencies in different countries, which set objectives to be reached with regard to glycated hemoglobin [4,5]. These guidelines are intended for practitioners in the daily care of diabetes. However, with the institution of standards, they are also an excellent tool available to health insurance companies and other agencies for assessing the performance of doctors, though they improperly infer the competency of the professionals involved from these observed overall performances.

The initial objective is completely commendable, since it incites physicians to introduce actions necessary for obtaining the best glycaemic control possible from their diabetic patients, with the aim of reducing diabetic complications and healthcare costs. In this context, and with the multiplication of the available therapeutic drug classes, the mean glycaemic control of the diabetic population has improved, being the result of a modification of the therapeutic choices, with intensification of diabetic treatments that correspond better to the present recommendations. In France, like in many other countries, glycaemic control remains insufficient however, with 41% of those with type 2 diabetes having an HbA1c that remains above the well-known 7% threshold, potentially exposing them to the “avoidable risk” of complications of the kidneys, eyes and nerves, as seen in the 2007-2010 ENTRED survey [6].

1. From insufficient glycaemic control to clinical inertia

Long restricted to metformin, sulfonylureas and insulin, the available therapeutic stock for glycaemic control has expanded over the last decades, and physicians thus find themselves now better equipped to manage hyperglycaemia. With the exception of a small proportion of patients, which presumably cannot be reduced, the treatments that are currently available should restore, under conditions of “active titration”, fixed HbA1c targets for diabetic patients. Why then do 41% of patients still not attain them? There are inherent factors that exist in patients, and some of them are known to have difficulties complying with lifestyle counseling and drug treatments. This phenomenon, which affects between 1/3 and nearly 100% of patients with type 2 diabetes according to the studies [7], certainly constitutes one of the barriers in reaching the HbA1c targets. The determinants of medication non-adherence are complex and remain very poorly understood. However it would be wrong to focus attention on the patient and overlook the role of the doctor-patient relationship. Too many doctors today still think that the best means of motivating diabetic patients is to play on their fears and to “put pressure on them” [8]. These consist of the well-known ultimatums: “If you don’t follow the diet, I’ll have to send you to the hospital and they’ll put you on insulin” or “If you aren’t careful, you’ll end up amputated, dialyzed, blind, etc.”, whereas the patient is waiting for a genuine partnership, support and a positive overall attitude [9]. The physician could therefore be partially responsible for his patients’ non-adherence with treatment. As if that were not enough, he might also be responsible for clinical inertia: perfectly aware that his patient is not sufficiently treated, he might deliberately decide not to intensify the therapy! This is a more recent concept, which was initially described by Phillips in 1999 in the field of diabetology [10], and then expanded to the management of other risk factors [11].

In a society that gives value to action, the term inertia cannot seem very rewarding to the physician for describing his clinical practice, thus becoming a real hindrance to the improvement of glycaemic control in his patients. It is nevertheless important to be especially careful in handling such concepts, which risk casting scorn on an entire profession, especially general practitioners (GPs), as they are the ones that exclusively monitor the large majority of patients in most countries [6]. This monitoring by GPs in France is very significant, with an average of 9 office or home visits per year and per patient, which is still not free from clinical inertia as shown in the DIAttitude study published in this supplement of Diabetes & Metabolism [12]. Thus GPs, the king pins of medicine, are saddled with this not very illustrious term of inertia, the direct opposite of the terms action and dynamism, which are so valued in our western societies of immediacy and performance.

2. Arguments of GPs confronted with inertia

2.1. The specificity of decisions in general medicine

Decisions made in general medicine have a certain distinctiveness compared to “classical” decisions in medicine. Traditionally the doctor collects biomedical data through questioning, which he then processes, as would a “researcher” or “investigator”, to obtain the highest diagnostic probability or to rule out the most severe hypothesis, all the while trying to minimize the risk of error as much as possible. Once the diagnosis is made, the doctor is prompted to apply scientific
Clinical inertia is usually defined by the absence of increase in drug therapy. The escalation of pharmacological therapy is not always the most relevant option however for resolving the problem. More than the augmentation of drug treatments, the proper response to the problem is the non-pharmacological prescription. This situation is far from being exceptional, and is otherwise well documented in the best practice guidelines. It has also been established that doctors usually use, and sometimes more beneficially, heuristic strategies (pragmatic decisional shortcuts during which the information is processed more broadly) instead of algorithmic strategies (deliberative process based on strictly logical sequential operations) [14]. In these situations it is possible that, with a heuristic vision, some doctors overcome the difficulties and resistance relative to this prescription [9] through pharmacologic augmentation. Others, while more or less aware that the failure is not directly related to the drugs, have trouble bringing themselves to escalate the therapy and attempt to avoid it as much as possible by trying to help the patient to somewhat change his lifestyle; they are then accused of inertia through the sole superficial analysis of their pharmacological prescriptions.

2.3.2. The patient presents distinct fragility related to comorbidities or advanced age

A broad quantitative analysis that does not take into account these types of conditions could hastily conclude that there is therapeutic inertia, whereas in fact it is only a reasoned adaptation of the objectives and treatment in a patient presenting with a complex and sometimes unclear clinical situation. These situations are not rare and are described in many recommendations. Doctors are often prompted to propose less strict objectives in order to avoid potential complications that can be severe and difficult to reverse. It is also possible that previous glycaemic intensification was attempted and then resulted in hypoglycaemia, thus impeding any new attempts. Hypoglycaemia is actually not a rare phenomenon in type 2 diabetes, affecting 30% of patients in studies on intensification of glycaemic control [15].

Finally, faced with a multifactorial approach and practicing patient-centered medicine, the doctor-patient pair is able to make decisions to intervene on parameters other than hyperglycaemia.

2.3.3. Priority was placed on another risk factor

Any doctor managing diabetic patients knows very well that during the same office visit he can find an HbA1c, LDL cholesterol and blood pressure that exceed all three target thresholds. Following explanation and discussion, the joint decision may be to introduce a statin, to adapt the antihypertensive treatment and to reassess the need for intensification of the glycaemic treatment at the next office visit after dietary efforts. Will the doctor be found to be inactive during this office visit?

2.4. Clinical inertia

It nevertheless has to be acknowledged that a certain degree of clinical inertia exists. Phillips et al. pointed out three factors that contribute to the failure of the doctor to undertake or intensify treatment when it is indicated. The first is that doctors overestimate the care that they provide (for example, they think that they check the HbA1c more often than they actually do). The second is the use of “good reasons” for the doctors to avoid intensification of the treatment, such as claims of life events making it temporarily impossible to follow “his diet” (end of year holidays, vacations, etc.) or “his physical activity orders” (bad weather, work, children, etc.). By mutual agreement, the doctor-patient pair will then be able to assume that everything will be better tomorrow. Sometimes
(often!) this situation persists and can last months and years until the occurrence of a medical or life event forces a change of strategy on the doctor-patient pair, sometimes incurring a delay that is detrimental to the health of the latter. We can also add situations of stalemate and the famous “there’s nothing that can be done about it”, a sort of “resignation” and “pseudo acceptance” [16]. Finally, the third factor is the lack of training in doctors on the therapeutic objectives and the means of attaining them. Maintenance of an HbA1c level lower than the target requires treatment intensification that is complicated by the multiplication of therapeutic classes, and which doctors are not always well prepared for [17,18].

We would also like to add a fourth reason: doubt. What if doctors did not believe or no longer believed in antidiabetic drugs, in studies, in guidelines and maybe even in glycaemic control? Indeed, how can there be belief in the beneficial effects of oral antidiabetics after the successive international withdrawal of rimonabant for its psychiatric risk [19], rosiglitazone for its cardiovascular risk [20], and pioglitazone in France for its bladder cancer risk [21], not to mention the Mediator scandal [22]? Doubt with regard to medication is growing, especially as the studies have not been able to clearly demonstrate the beneficial effects of glycaemic control [14], not to mention the increased risk of mortality highlighted by the ACCORD study [23]; also in France, the French National Authority for Health decided to withdraw the recommendations because of undeclared conflicts of interest of the writers [24]. The application of the recommendations certainly requires a strong belief, which is surely difficult in such a context.

3. Is there a role for the diabetologist in the fight against clinical inertia?

The transition in the disease model from an acute state to a long term chronic state of illness. occurred very rapidly in the 20th century and requires a paradigm shift in the medical world. Chronic diseases react little or not at all to management based on the acute disease model and require a patient-centered approach, which both GPs and specialists have only been slightly exposed to in their initial training or continuing medical education. Traditionally, during medical studies in France, students learn to gather biomedical data through questioning and are thus able to form a diagnosis; they then learn to prescribe drug treatments through knowledge and the applications of algorithms. While antibiotic treatment would not be refused (at least rarely in any case!) for any patient presenting cough, chest pain, fever, and difficulty breathing, and in whom the diagnosis of acute lobar pneumonia is made, what about the asymptomatic person who, at his “50-year check-up”, presents with glycaemia barely exceeding 1.26g/L? It can be understood that in the first case the doctor uses his powers of persuasion to attempt to have the treatment applied, but how far should he go and what strategy should he use in the second case to convince the person to take an oral antidiabetic drug? Is it even his role to convince or should he provide all the information necessary for the patient to decide himself whether or not it is in his interest to take the treatment? By training, won’t the doctor have a tendency to function according to a similar pattern, attempting to apply to the patient what he himself thinks is a good choice? It is then a matter of a “disease – or doctor – centered decision” and not a “patient-centered approach”, which would require a fine analysis of the clinical situation together by the doctor-patient pair, by integrating the psychosocial context so that the latter can make an informed choice concerning his treatment. In this setting, the doctor is no longer there to decide and prescribe but to inform and clarify.

Well aware of this problem, the departments of general medicine have certainly been the first to direct the training of the general medicine residency towards patient-centered medicine. However these departments are still very young in France, with the appointment of the first general medicine-associated professors dating from 1991, and the majority of currently practicing GPs have not received this training. To the credit of the diabetologists, they were among the first, if not the first, to invest in therapeutic education, an approach that is (or should be?) essentially centered on the person, and most of them have recognized expertise in this area. With their respective specificities, diabetologists and GPs have complementary strengths that can be developed on different levels for fighting against clinical inertia and improving the overall management of diabetic patients.

3.1. The diabetologist, an expert in therapeutic education and a patient “activator”

Diabetologists are admittedly specialists in diabetes. In that capacity, they are the ones that best know the monitoring to be done and the handling of the antidiabetic treatments, the difficulty of which has been seen with the multiplication of therapeutic classes and side effects. This technical nature of the specialist does not necessarily constrain him however to a disease-centered approach. Indeed, therapeutic education, an approach centered on the person, is historically related to diabetes and was first developed by diabetologists. Diabetologists in fact long ago understood that patients treated with insulin should learn to manage their treatment in order to be autonomous, thus requiring a transfer of skills. Likewise, in type 2 diabetes, the role of diabetologists is not restricted to assisting in the choice of drug treatment or the “diet” prescription, but consists of a transfer of knowledge and skills to the patients, thus enabling them to actively participate in their choice of treatments. This patient “activation” is rooted in the acquisition of knowledge, encouraging them to participate more during encounters with the GP. GPs are then better able to define the expectations of their patients, to the benefit of the glycaemic control [25].

3.2. The diabetologist, an outsider view

In general medicine in France, the doctor-patient relationship is made to last, with patients retaining a certain
loyalty to their attending physician. This relationship enables doctors to have knowledge of their patients, their families and their psychosocial context, much more specific than that of specialists. They will then have in that capacity much greater ease adapting the care to the context of the patient. But the problem is that, as in any couple relationship, certain quirks, which can be easily seen by an outsider, end up being overlooked. It was thus shown that doctors that had a prior relationship with their patients did not have better knowledge of their expectations [26]. Specialist can therefore offer an outside view and provide a different perspective, revealing problems that the attending physician-patient pair relationship had obscured.

3.3. The diabetologist office visit, a time committed to diabetes

Even if he decides to devote a specific office visit to diabetes, it will be very difficult for the attending physician to avert questions of another nature that will inevitably interfere with the actual diabetes management. As the office visit time is necessarily limited, each problem raised by the patient will compete with the management of diabetes. And yet, the more the “diabetes office visit” is “contaminated” by related questions, the less chance of treatment intensification for equivalent HbA1c [27]. The office visit with the diabetologist is a time that is dedicated to diabetes, in which there is much less risk of addressing a related problem.

4. Conclusions

Clinical inertia! Is this concept really suitable for explaining the difficulties encountered by GPs in intensifying the treatment of type 2 diabetes? Without a doubt, it is the result of a culture focused on figures and evaluations. Based only on the concept of absence of drug treatment intensification, clinical inertia will most likely serve as a sound box to the pharmaceutical industry to promote drug prescription. We should therefore be vigilant and not forget that the majority of diabetics that are not at the target levels receive treatment intensification within a reasonable time frame [28], although the results are variable according to the studies [12]. It is not a matter for us here to reject the concept but to advocate a more integrative vision, which takes into account the ideas of a multifactorial approach, patient-centered medicine and personalization of treatment [29]. Far from being rivals, GPs and diabetologists should constitute a duo, developing synergistic strengths so that each of our patients can make positive autonomous health choices [30]. This cooperation is essential for controlling the complications of diabetes in the greater interest of our patients and our healthcare systems.

Disclosure of interest

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