

L'INERZIA CLINICA

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Clinica Medica 3

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Clinical Inertia

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Medicine has traditionally focused on relieving patient symptoms. However, in developed countries, maintaining good health increasingly involves management of such problems as hypertension, dyslipidemia, and diabetes, which often have no symptoms. Moreover, abnormal blood pressure, lipid, and glucose values are generally sufficient to warrant treatment without further diagnostic maneuvers. Limitations in managing such problems are often due to *clinical inertia*—failure of health care providers to initiate or intensify therapy when indicated. Clinical inertia is due to at least three problems: overestimation of care provided; use of “soft” reasons to avoid intensification of therapy; and lack of education, training, and practice organization aimed at achieving therapeutic

goals. Strategies to overcome clinical inertia must focus on medical students, residents, and practicing physicians. Revised education programs should lead to assimilation of three concepts: the benefits of treating to therapeutic targets, the practical complexity of treating to target for different disorders, and the need to structure routine practice to facilitate effective management of disorders for which resolution of patient symptoms is not sufficient to guide care. Physicians will need to build into their practice a system of reminders and performance feedback to ensure necessary care.

Ann Intern Med. 2001;135:825-834.


For author affiliations and current addresses, see end of text.

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Clinical Inertia or Therapeutic Inertia

Phillips et al. (2001): “failure of health care providers to initiate or intensify therapy when indicated” and “recognition of the problem, but failure to act.”



Okonofua et al. (2006) : “failure of providers to begin new medications or increase dosages of existing medications when an abnormal clinical parameter is recorded.”

Clinical inertia

Clinical inertia is more than failure to act, and it has been shown that other factors such as **clinician communication affect adherence.**

a meta-analysis of 127 studies showed that the odds of adherence for patients whose physicians had been trained in communication skills were 1.62 times those of patients whose physicians did not receive communication training.

(Zolnierek and DiMatteo (2009))

Factors contributing to apparent clinical inertia

Clinician ^b	Patient	Health System
<ul style="list-style-type: none"> • Failure to initiate treatment • Failure to titrate treatment to goal • Failure to set clear goals • Underestimation of patient need • Failure to identify and manage comorbid conditions such as depression • Insufficient time • Insufficient focus or emphasis on goal attainment • Reactive rather than proactive care 	<ul style="list-style-type: none"> • Medication side effects • Too many medications • Forgetfulness • Cost of medication • Denial of disease • Denial of disease severity • Perception of low susceptibility • Absence of disease symptoms • Mistrust of clinician • Poor communication with clinician • Low health literacy • Mental illness, depression, substance abuse • Lifestyle 	<ul style="list-style-type: none"> • No clinical guideline • No disease registry • No visit planning • No active patient outreach • No decision support • No team approach to care or lack of care coordination • Poor communication between clinician and office staff

^aDerived in part from O'Connor et al.(2005).⁴

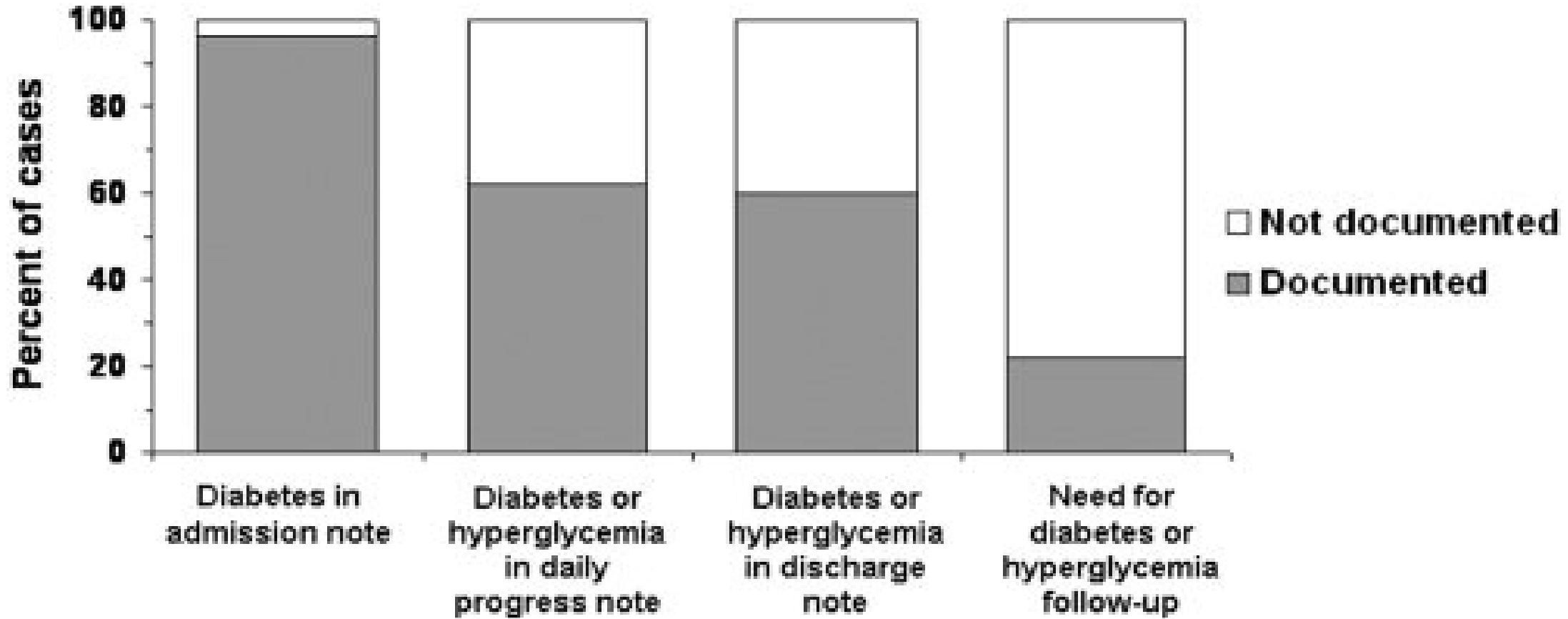
^bO'Connor et al. use the term "physician factors" with occasional reference to "providers,"⁴ and Phillips et al.(2001) use the terms "physicians" and "health care providers" interchangeably.²

COMPETING DEMANDS OR CLINICAL INERTIA?

Is the failure to aggressively advance care along evidence-based guidelines (termed *clinical inertia*) a failure of medical practice?

Is balancing multiple problems, including those not guided by evidence-based guidelines (termed *competing demands* or *competing opportunities*), a fundamental feature of the added value of primary care?

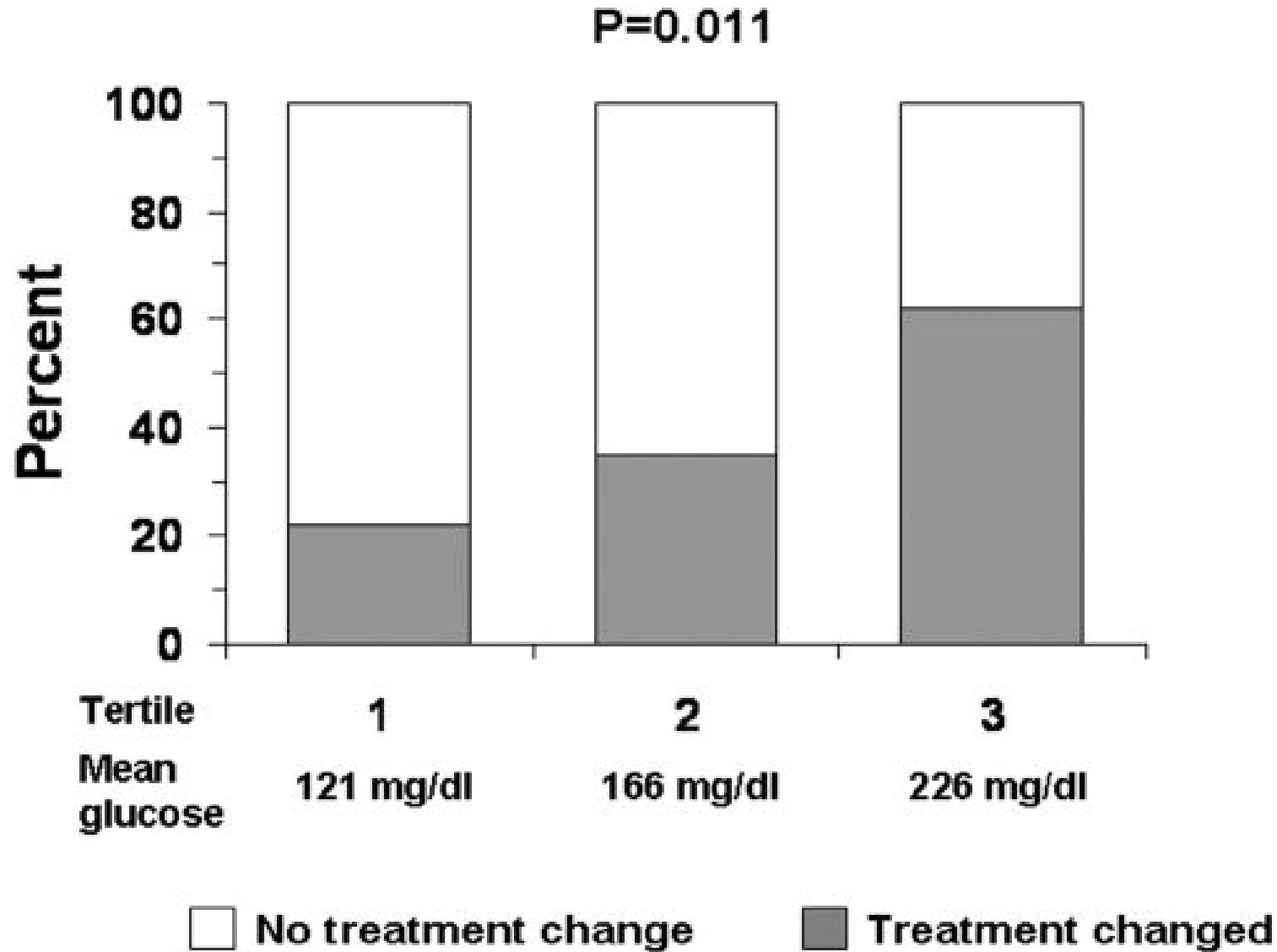
Diabetes care in the hospital: Is there clinical inertia?



Diabetes care in the hospital: Is there clinical inertia?



Diabetes care in the hospital: Is there clinical inertia?



DELAY IN DIAGNOSIS OF DIABETES IS NOT THE PATIENT'S FAULT

Our review reveals that delay in diagnosis of diabetes cannot be attributed to patient nonadherence as a result of missing appointments or blood tests.

To the contrary, there were multiple opportunities when a diagnosis could have been but was not made, suggesting provider factors (clinical inertia) as the cause of delay.

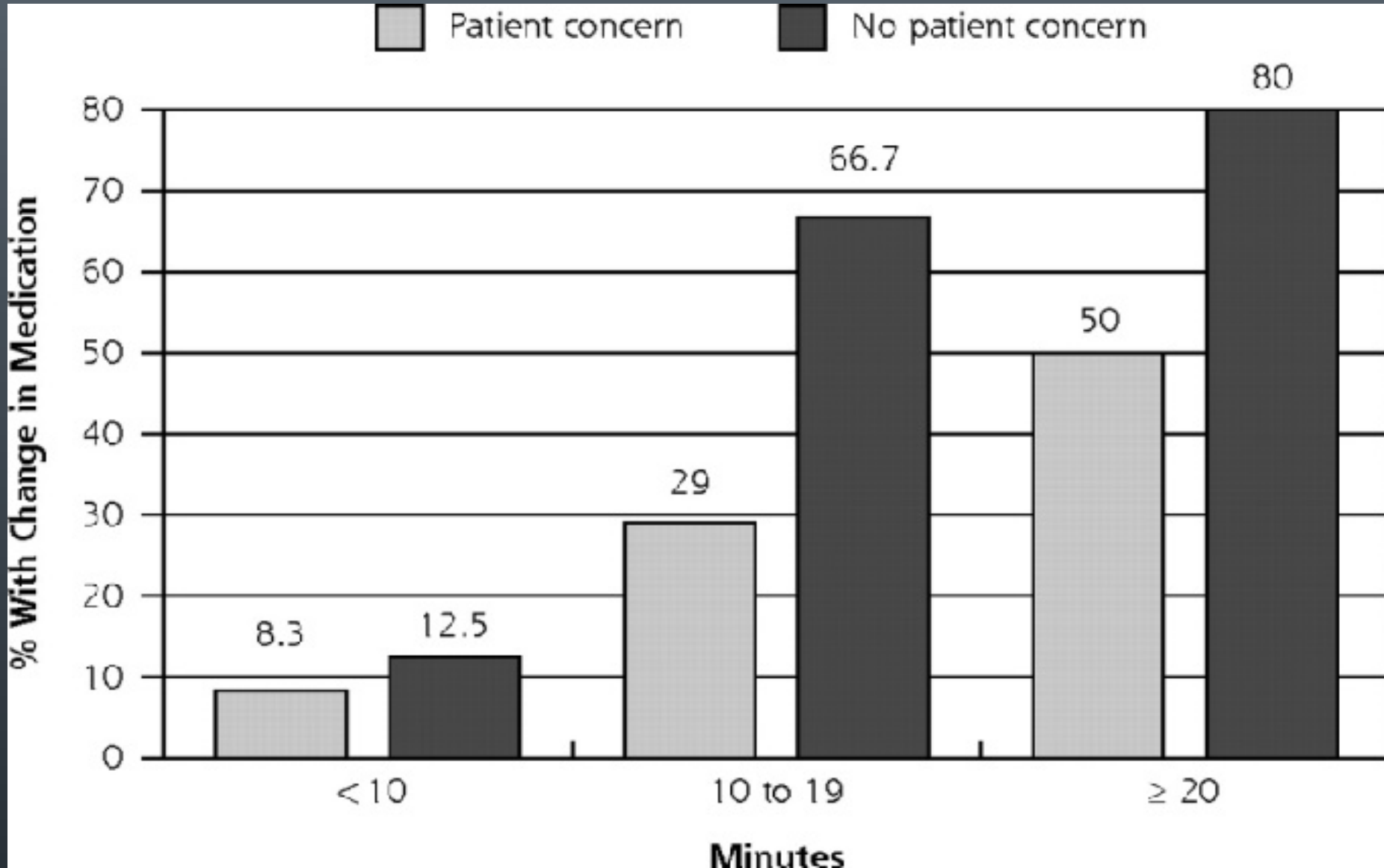
Table 2. Changes in Medication by Patient and Encounter Characteristics if Hemoglobin A_{1c} Value Was Greater Than 7% (n = 98)

Characteristic	Change in Medication Mean (SD) or %	No Change in Medication Mean (SD) or %	P Value
Patient characteristics			
Age, years	57.5 (13.2)	56.7 (13.5)	.76
Female, %	54.9	50.0	.55
Hispanic, %	60.8	59.6	.88
Number of comorbidities	4.8 (2.2)	4.3 (1.9)	.22
Hemoglobin A _{1c} , %	8.6 (2.1)	7.3 (1.7)	<.001
Previous hemoglobin A _{1c} level worse, %	51.5	50.9	.95
Number of long-term medications	7.09 (3.14)	5.51 (2.92)	.02
Encounter characteristics			
Number of patient concerns	1.5 (1.3)	2.4 (2.1)	.04
Number of topics discussed by physician	13.4 (4.49)	11.3 (5.05)	.05
Length of encounter, minutes	19.4 (7.2)	15.4 (7.8)	.02
Number of days since last measured hemoglobin A _{1c}	70.8 (94.8)	110.2 (170.5)	.07
Percentage of encounter devoted to:			
Discussing nutrition	5.23 (6.25)	2.91 (4.76)	.07
Discussing exercise	1.50 (2.24)	1.71 (3.20)	.77
Discussing medication compliance	7.47 (6.76)	7.79 (6.09)	.83
Percentage of encounter time until:			
Evaluation/feedback of test results	48 (0.29)	0.62 (0.80)	.44
Discussion of planning treatment	74 (0.28)	0.80 (0.43)	.57

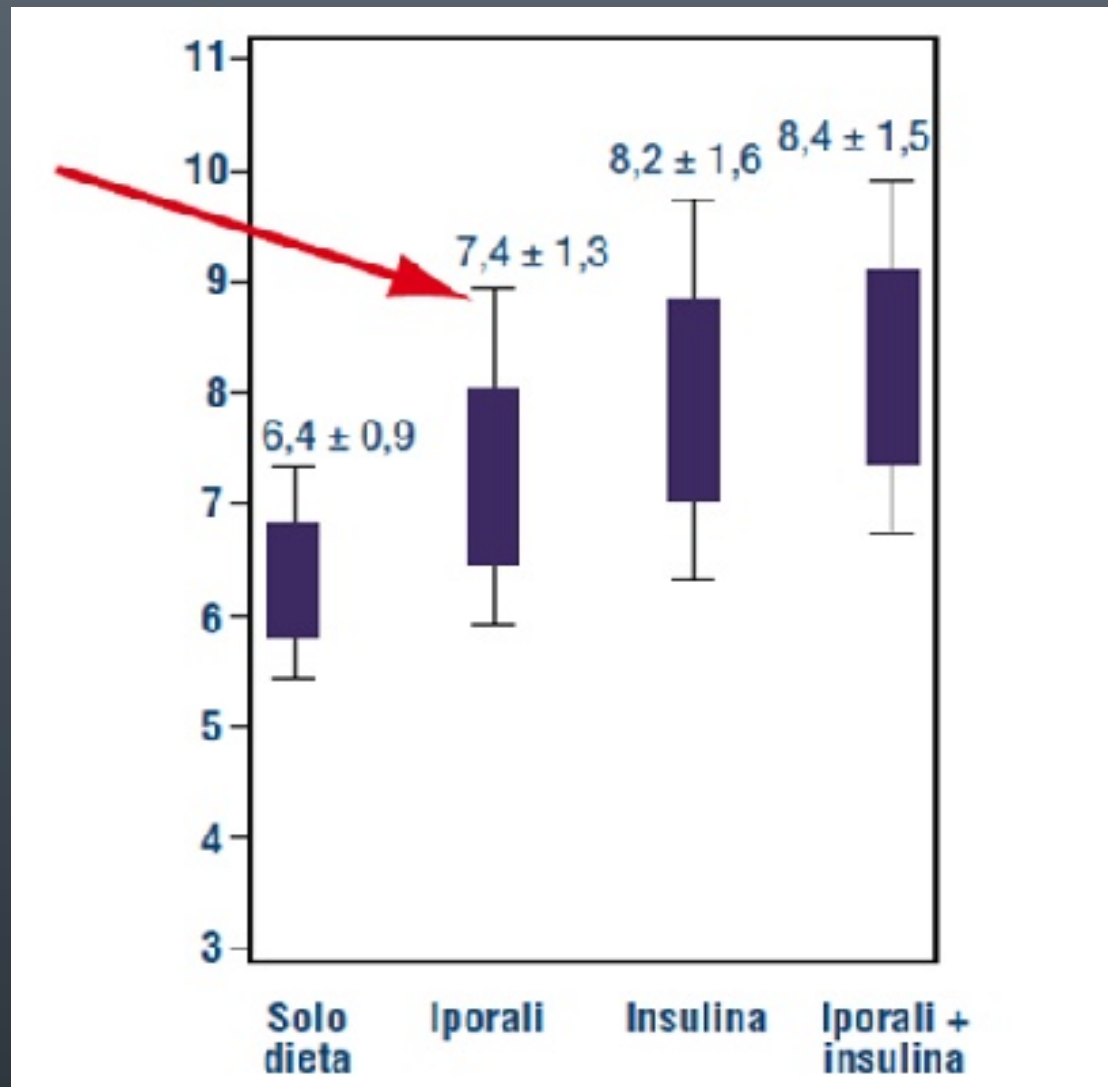
Hemoglobin A_{1c} = glycosylated hemoglobin.

Competing Demands or Clinical Inertia: The Case of Elevated Glycosylated Hemoglobin

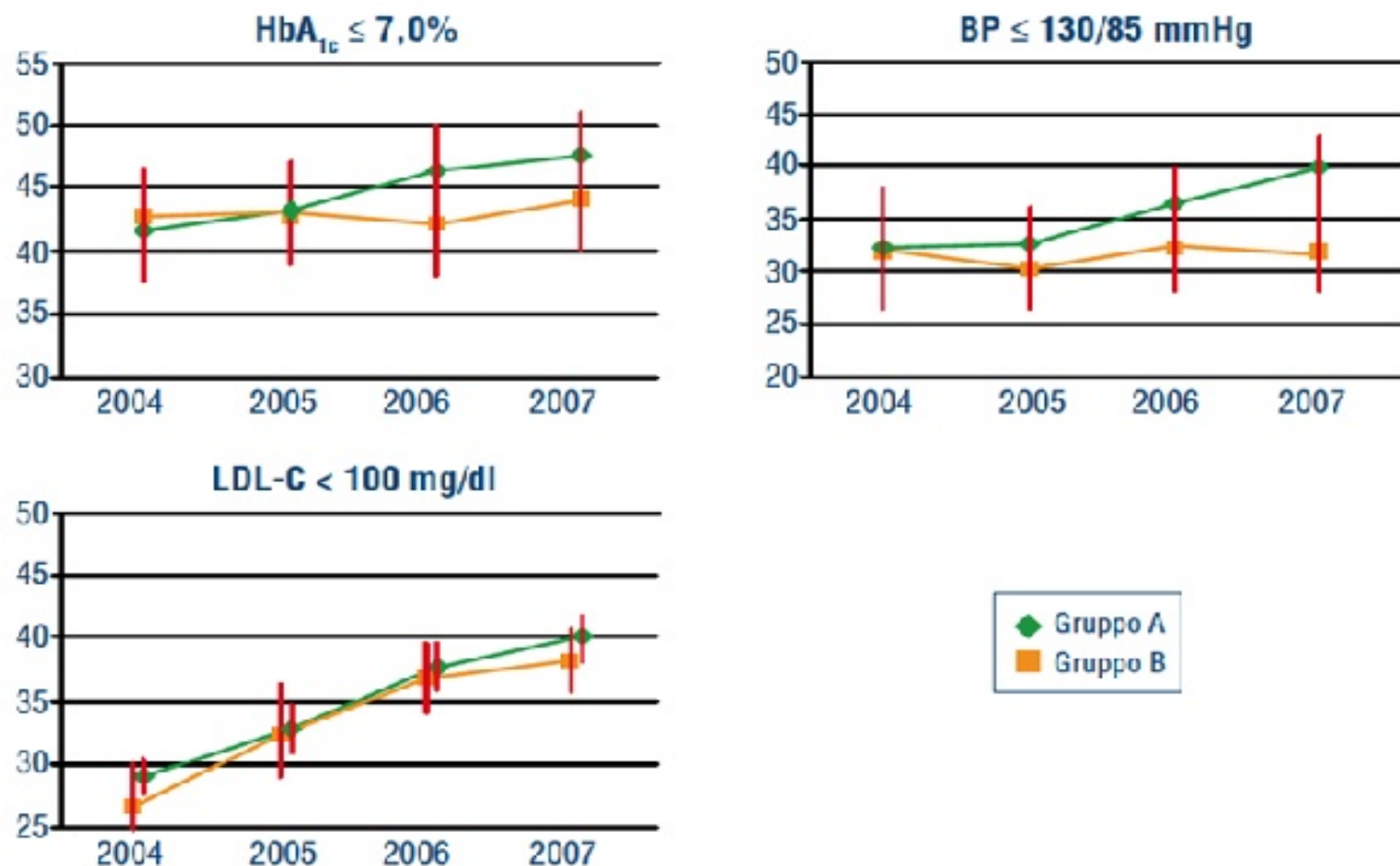
Percentage of patients with a change in medication, by encounter length and presence of patient concerns.



HbA_{1c} media e d.s. (ultimo valore normalizzato a 6,0) per tipo di trattamento nei diabetici di tipo 2



Indicatori di esito intermedio

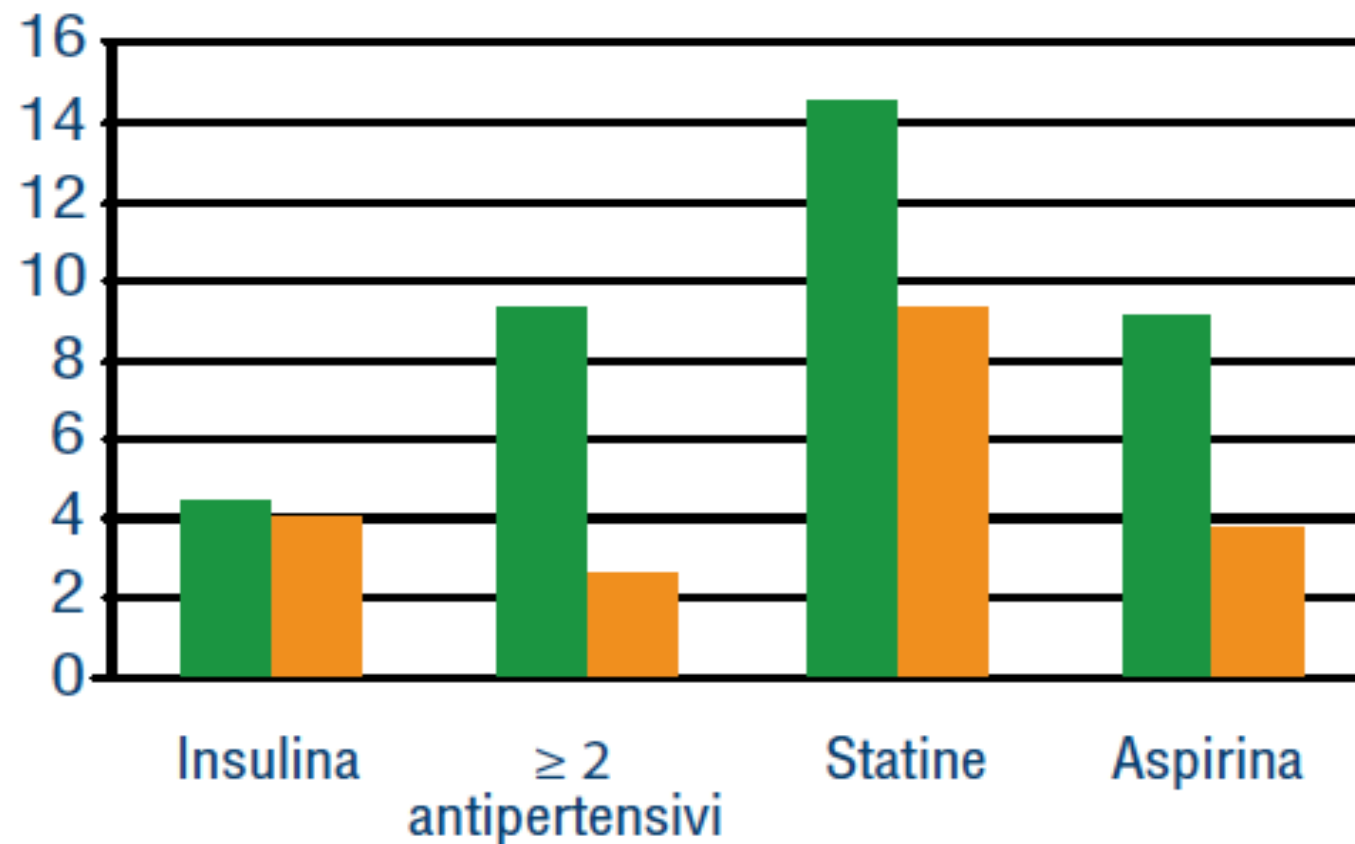


Andamento su 4 anni della percentuale di pazienti a target per HbA_{1c}, LDL e pressione in servizi che hanno aderito all'iniziativa Annali nel 2004 (gruppo A) e nel 2007 (gruppo B) (da Nicolucci et al., 2010, mod.).

Variazioni 2007-2004

■ Gruppo A
■ Gruppo B

Uso di farmaci



Incremento dell'uso di alcune classi di farmaci in servizi che hanno aderito all'iniziativa Annali nel 2004 (gruppo A) e nel 2007 (gruppo B) (da Nicolucci et al., 2010, mod.).

Inerzia terapeutica: gli ostacoli del sistema

**Controllo
ossessivo
della spesa**

**Piani
terapeutici**

**Carenza
di personale
per istruire
il paziente**

(ticket)

Le responsabilità del sistema.

Inerzia terapeutica: resistenze del paziente

```
graph TD; A["Inerzia terapeutica:  
resistenze del paziente"] --> B["Avversione verso  
l'eccesso  
di farmaci  
da assumere"]; A --> C["Percezione  
dell'intensificazione  
della terapia  
come aggravamento  
della malattia"]; A --> D["Rifiuto  
della terapia  
iniettiva"];
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**Avversione verso
l'eccesso
di farmaci
da assumere**

**Percezione
dell'intensificazione
della terapia
come aggravamento
della malattia**

**Rifiuto
della terapia
iniettiva**

Clinical Inertia as a Clinical Safeguard

- Why physicians—who may have knowledge of and may be familiar with standard-of-care guidelines—seem to be subject to clinical inertia is still an open question. However, there may be an alternative interpretation for the phenomenon: **clinical inertia may be a clinical safeguard for the drug-intensive style of medicine fueled by the current**

Giuliano D & Catherine Esposito JAMA. 2011;305(15):1591-1592

medical literature.

ACCORD, ADVANCE, and VADT Trials Research Question



Does Intensive Glucose Control
Reduce Risk for Cardiovascular
Disease in Type 2 Diabetes?

ACCORD Study Group, *NEJM* 2008, 358:2545-2559.

ADVANCE Collaborative Group, *NEJM* 2008, 358:2560-2572.

VADT Study Results ADA Scientific Session San Francisco, 2008

In Press, *Diabetes Obesity and Metabolism*, 2008

ACCORD, ADVANCE and VADT Study Design

	ACCORD	ADVANCE	VADT
Major Endpoints	CV death, Non-fatal MI/Stroke	CV death, Non-fatal MI/Stroke, macrovascular event	CV death, Non-fatal MI/Stroke, CHF macrovascular event
Study design	RCT	RCT	RCT
design	Glucose Intensive vs Standard Arm 2x2 BP control +/-fenofibrate v placebo	Glucose Intensive vs Standard Arm 2x2 Perindopril +indamide v placebo	Glucose Intensive vs Standard Arm 2x1 All received BP and Lipid Rx

ACCORD Study Group, *NEJM* 2008, 358:2545-2559.

ADVANCE Collaborative Group, *NEJM* 2008, 358:2560-2572.

VADT Study Results ADA Scientific Session San Francisco, 2008

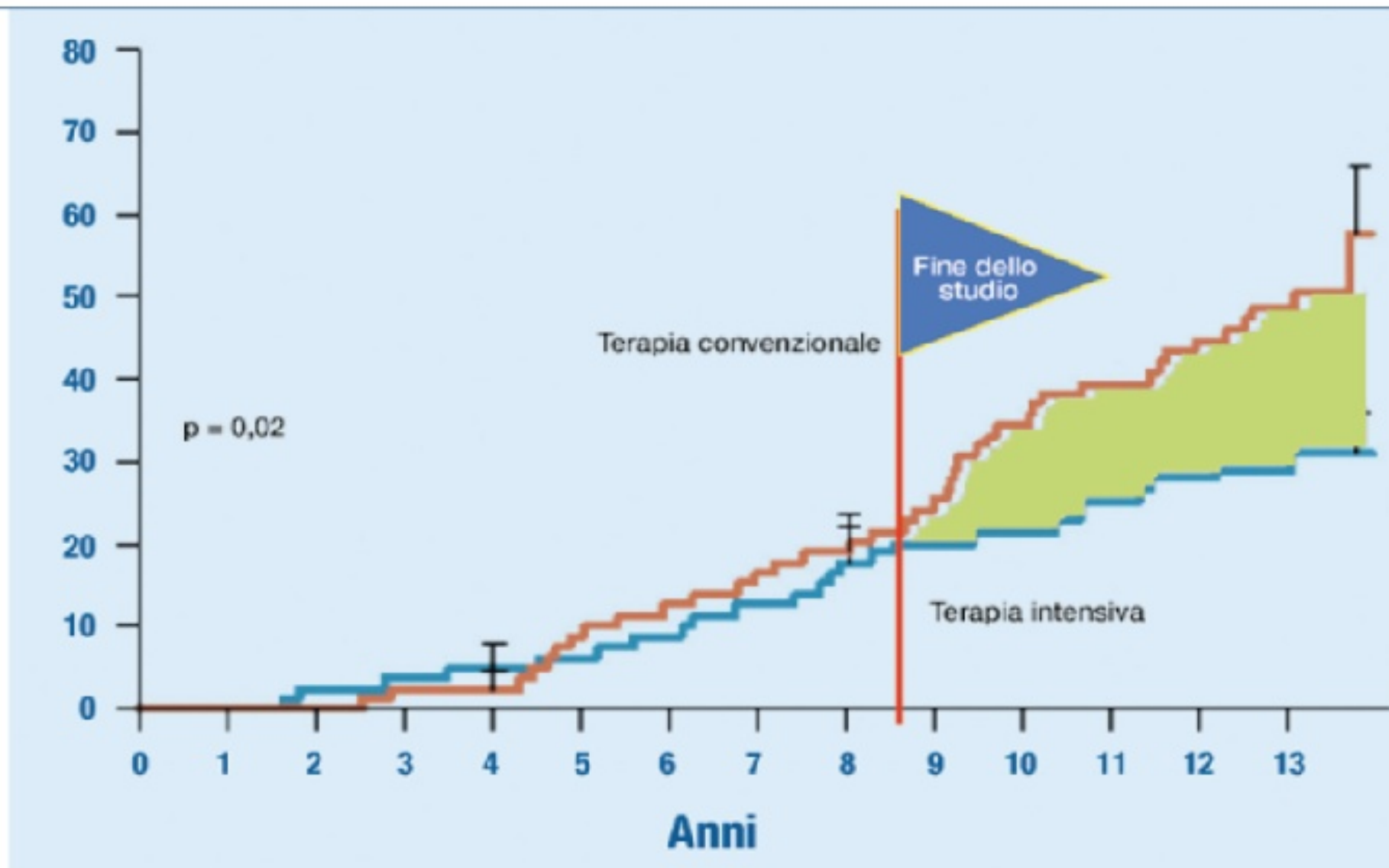
In Press, *Diabetes Obesity and Metabolism*, 2008

ACCORD, ADVANCE, and VADT

Lessons Learned



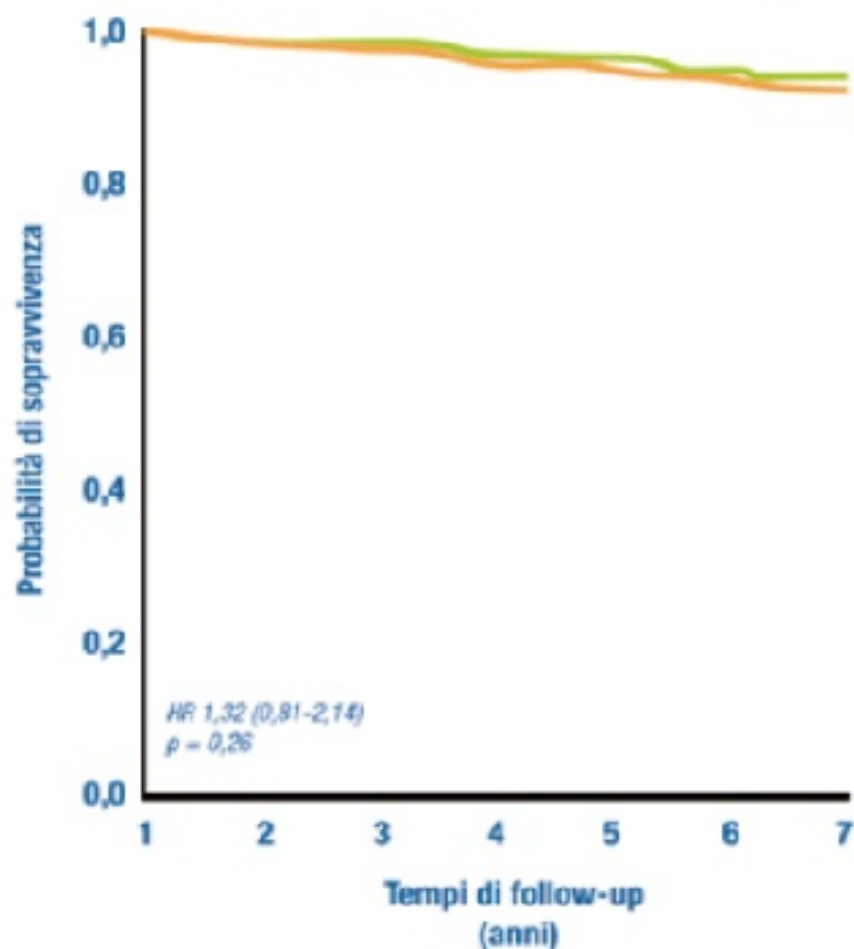
- Intensive glucose control does not reduce CVD mortality in T2DM, and *may* increase risk, especially in patients with pre-existing CHD
- Aggressive A1c targets (<6.5%) were associated with a 3-fold increased risk hypoglycemia



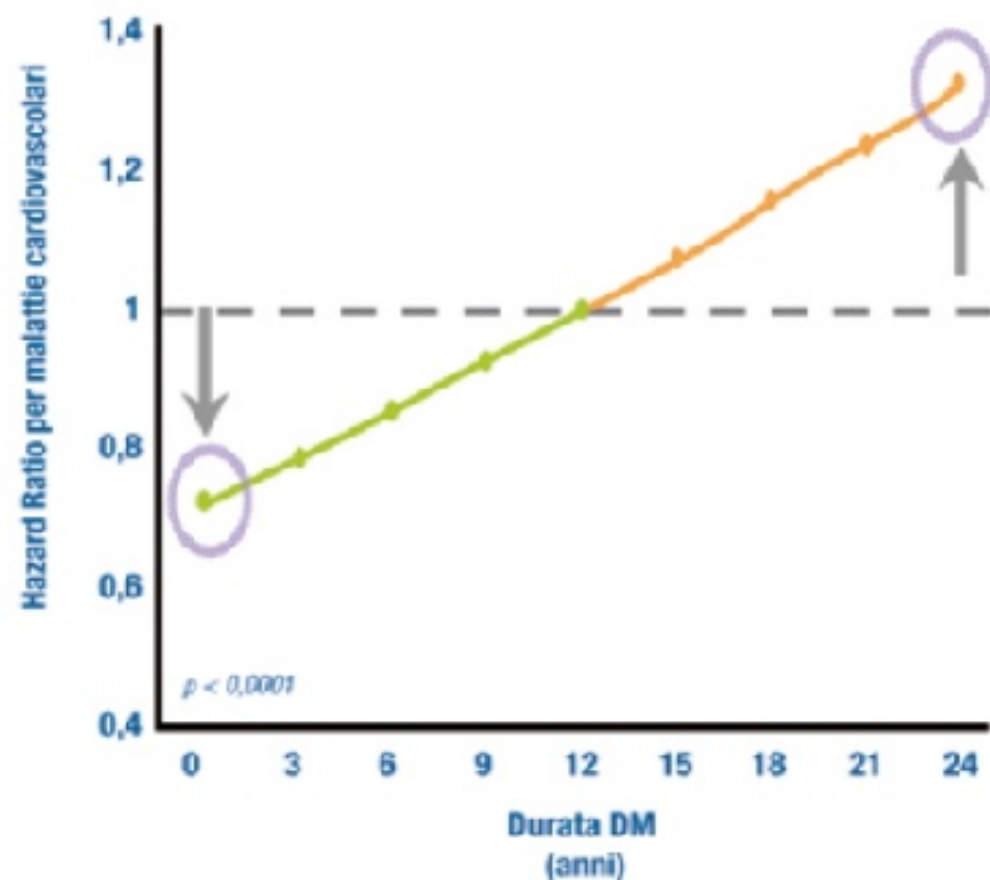
La peggior prognosi persiste dopo la fine dello studio.

Legacy Effect (memoria metabolica) nel diabete mellito di tipo 2: il trial STENO2.

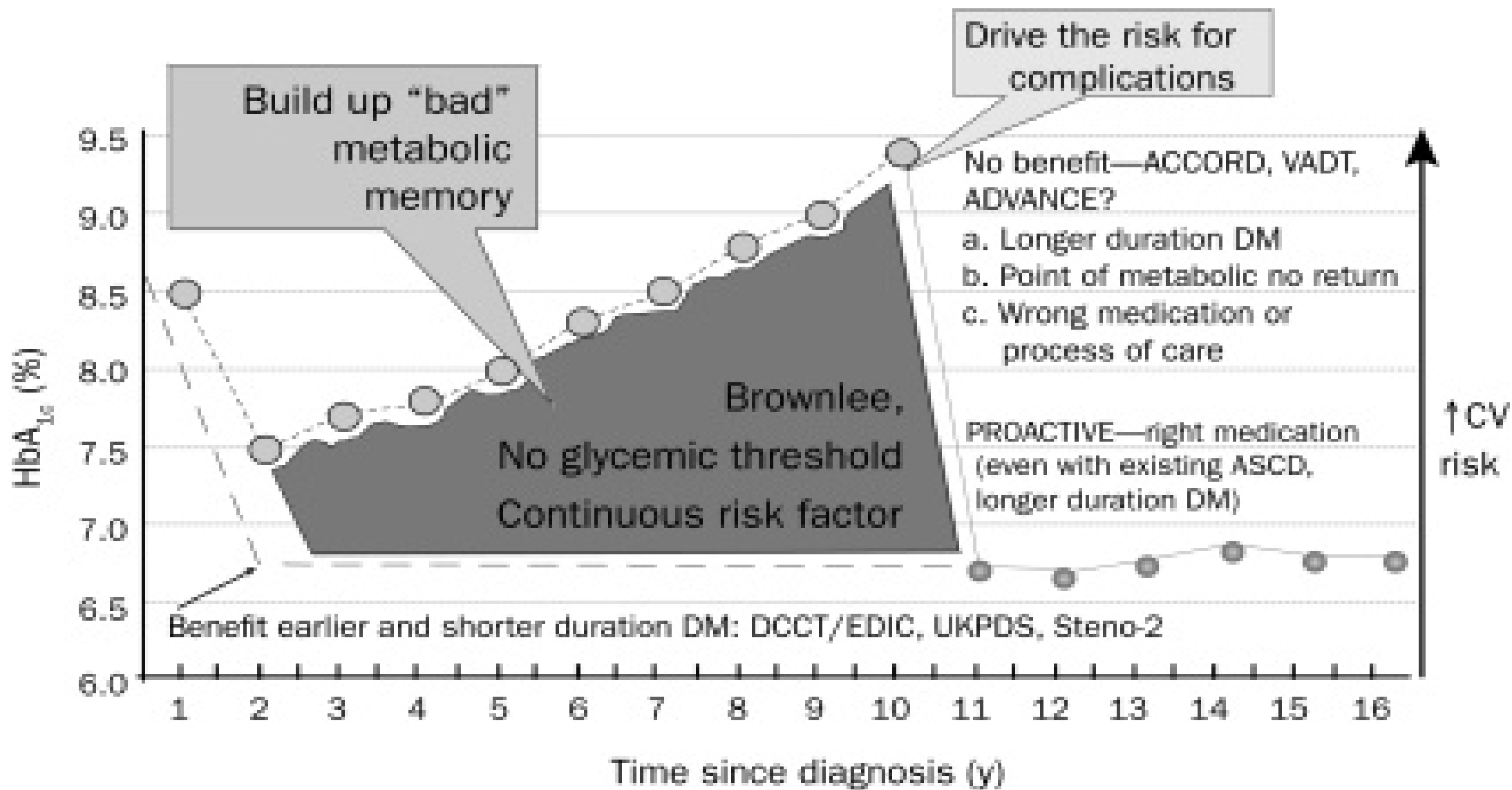
Decesso per cause cardiovascolari (terapia standard vs. intensiva)



Rapporto tra la durata del diabete e l'HR per eventi cardiovascolari con terapia intensiva



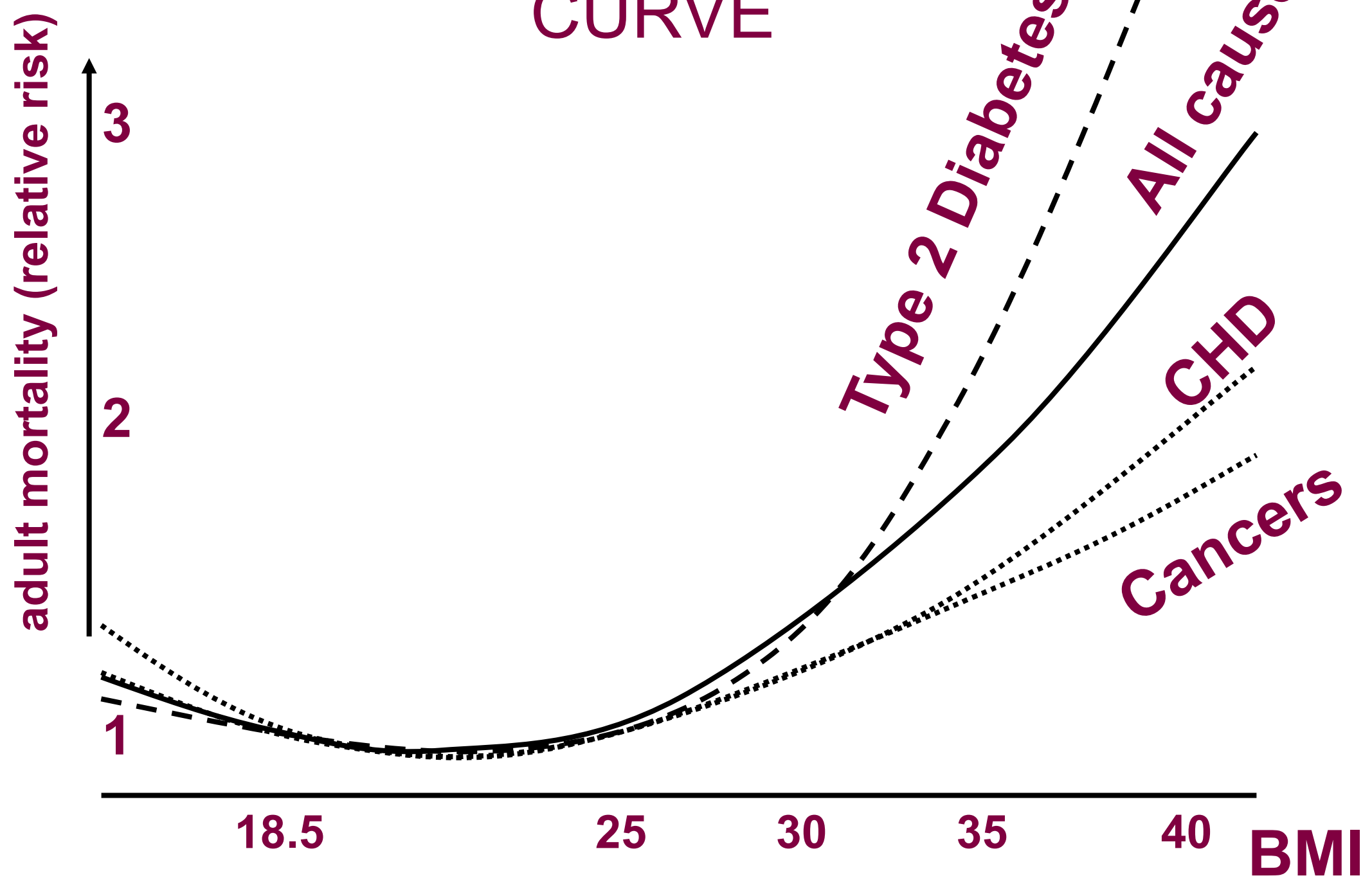
Efficacia nella prevenzione cardiovascolare della terapia intensiva in relazione alla durata del diabete (da Duckworth et al., 2009, mod.).



Clinical Inertia and Uncertainty in Medicine

- Although clinical inertia may reflect uncertainty regarding the precise goals of treatment and disagreement with clinical guidelines, data show that other factors are more common. Lack of familiarity with guidelines, lack of confidence in ability or preparation, and external barriers such as time limitations better explain why physicians do not follow practice guidelines
-While inaction may sometimes be the best option, more often physicians should act but do not. Ignoring the best available evidence is rarely the best approach.

THE EPIDEMIOLOGICAL J CURVE



Impact of Weight Loss on Risk Factors



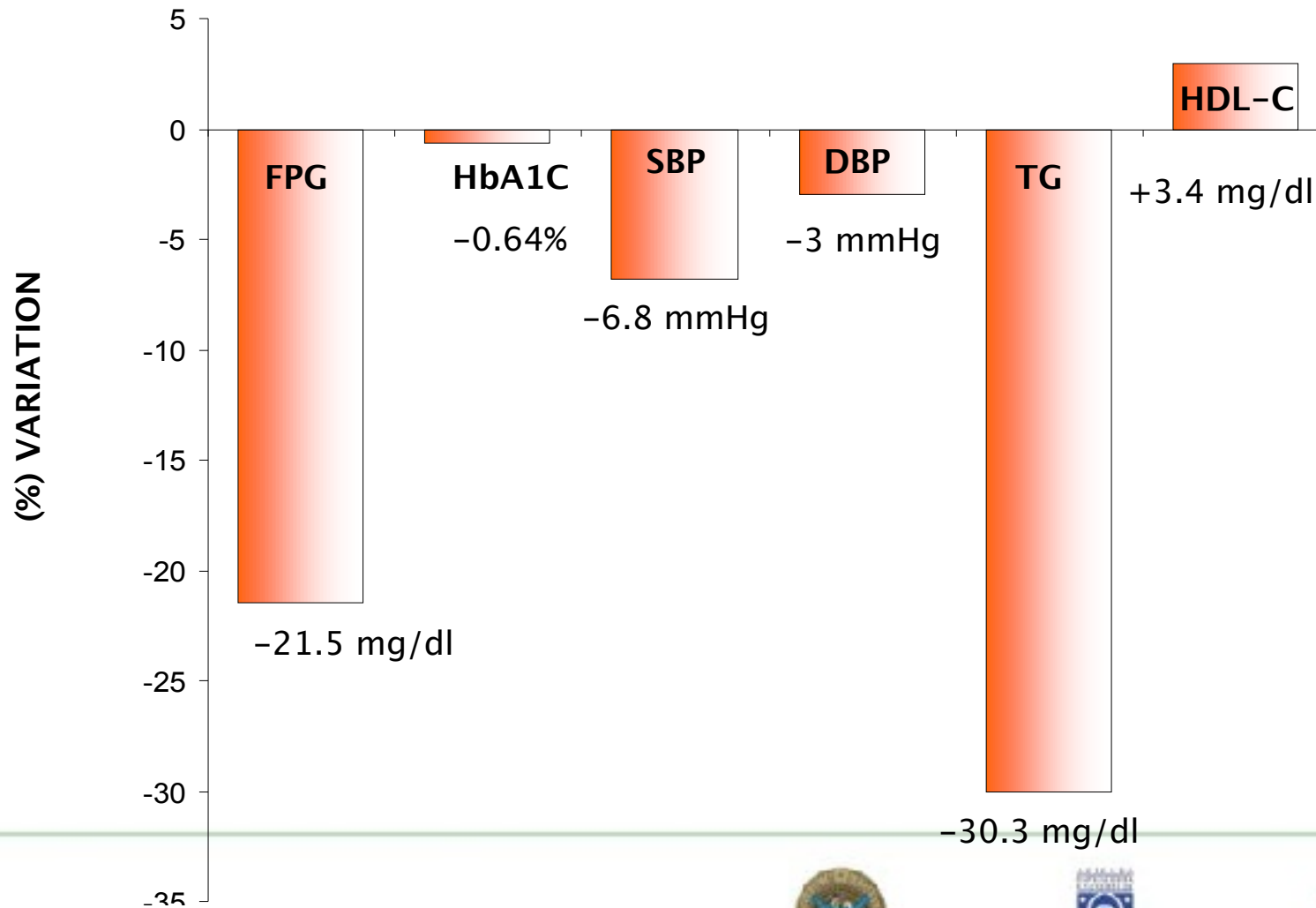
	~5% Weight Loss	5%-10% Weight Loss
HbA1c	↓ 1	↓ 1
Blood Pressure	↓ 2	↓ 2
Total Cholesterol	↓ 3	↓ 3
HDL Cholesterol	↑ 3	↑ 3
Triglycerides		↓ 4



Action for Health in Diabetes (Look AHEAD): effetti della riduzione del peso in soggetti sovrappeso con DM2



* After 8.6% weight reduction by lifestyle modifications





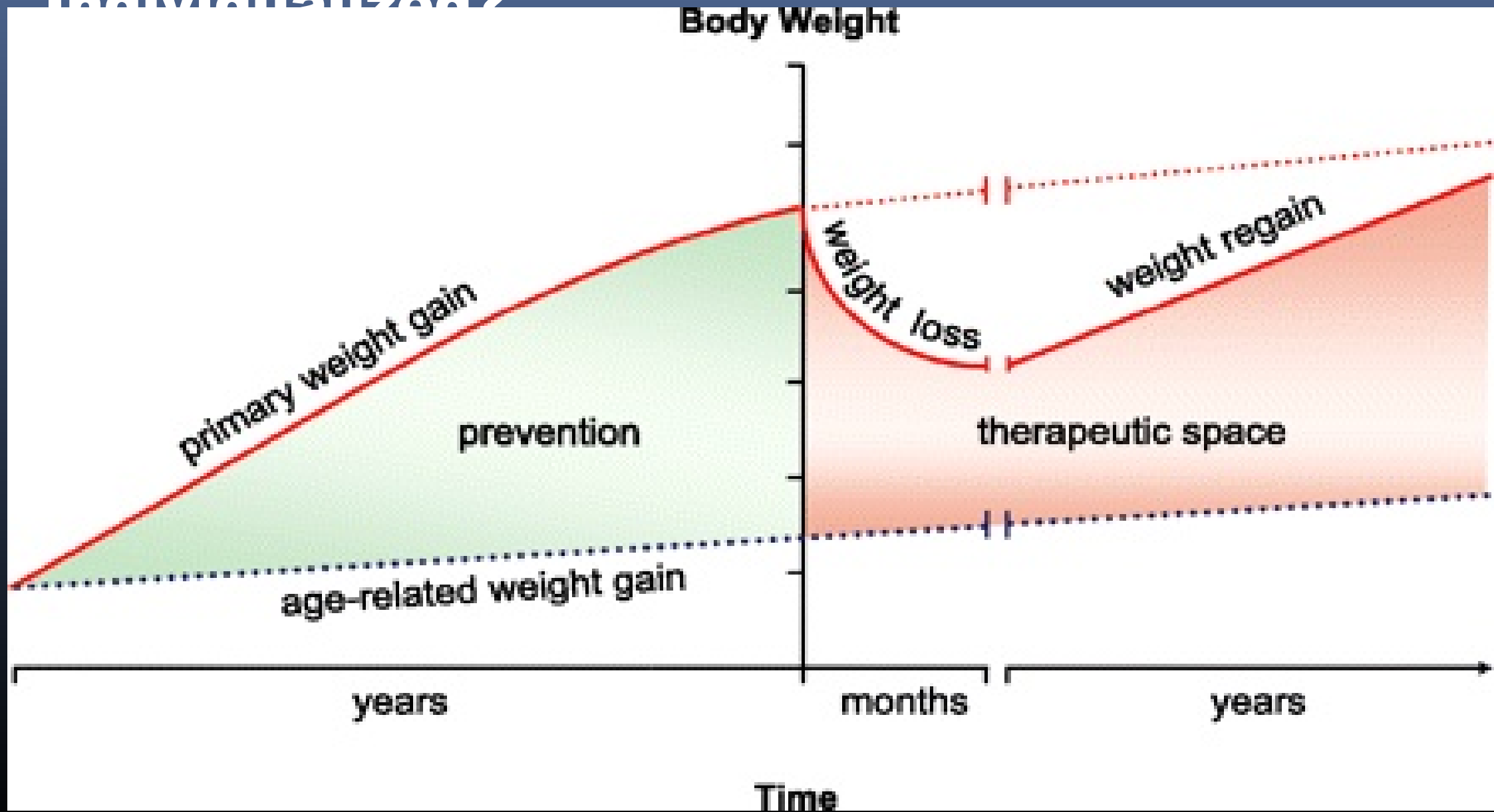
La terapia dell'obesità:

un caso di inerzia
clinica e

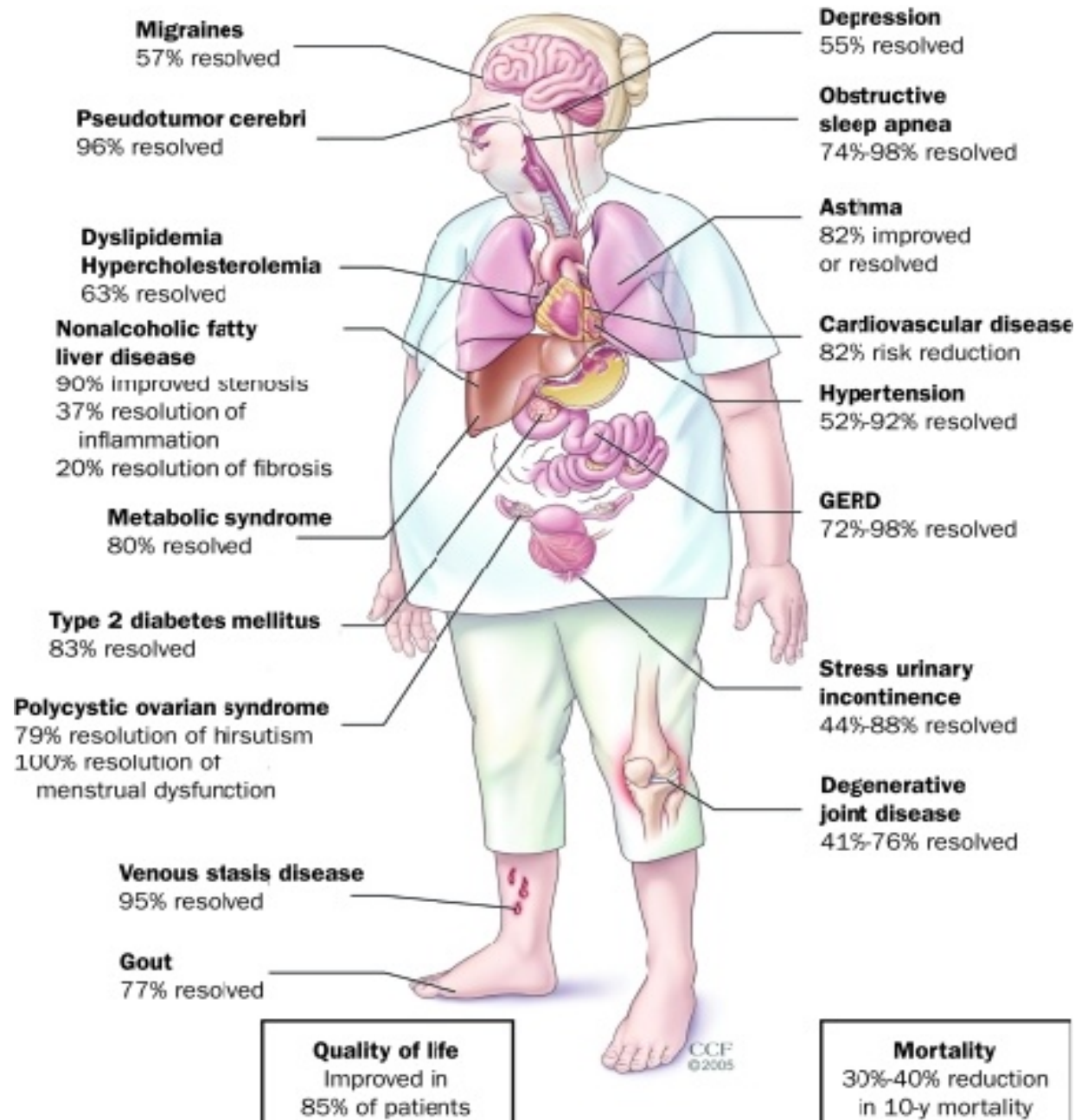
terapeutica assoluta?



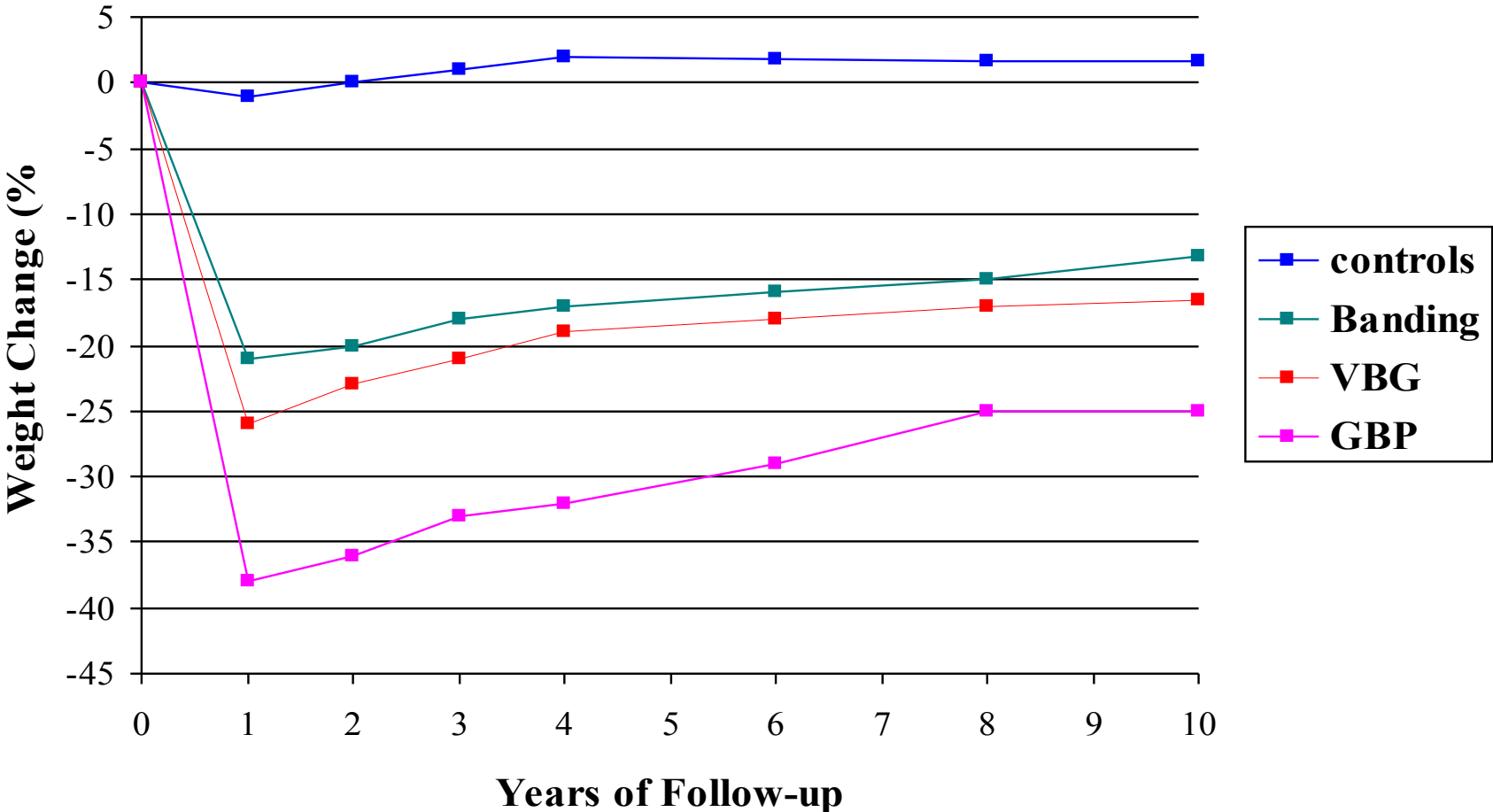
Obesity and Type 2 Diabetes: What Can Be Unified and What Needs to Be Individualized?



Comorbidities reduced after bariatric surgery and weight loss.

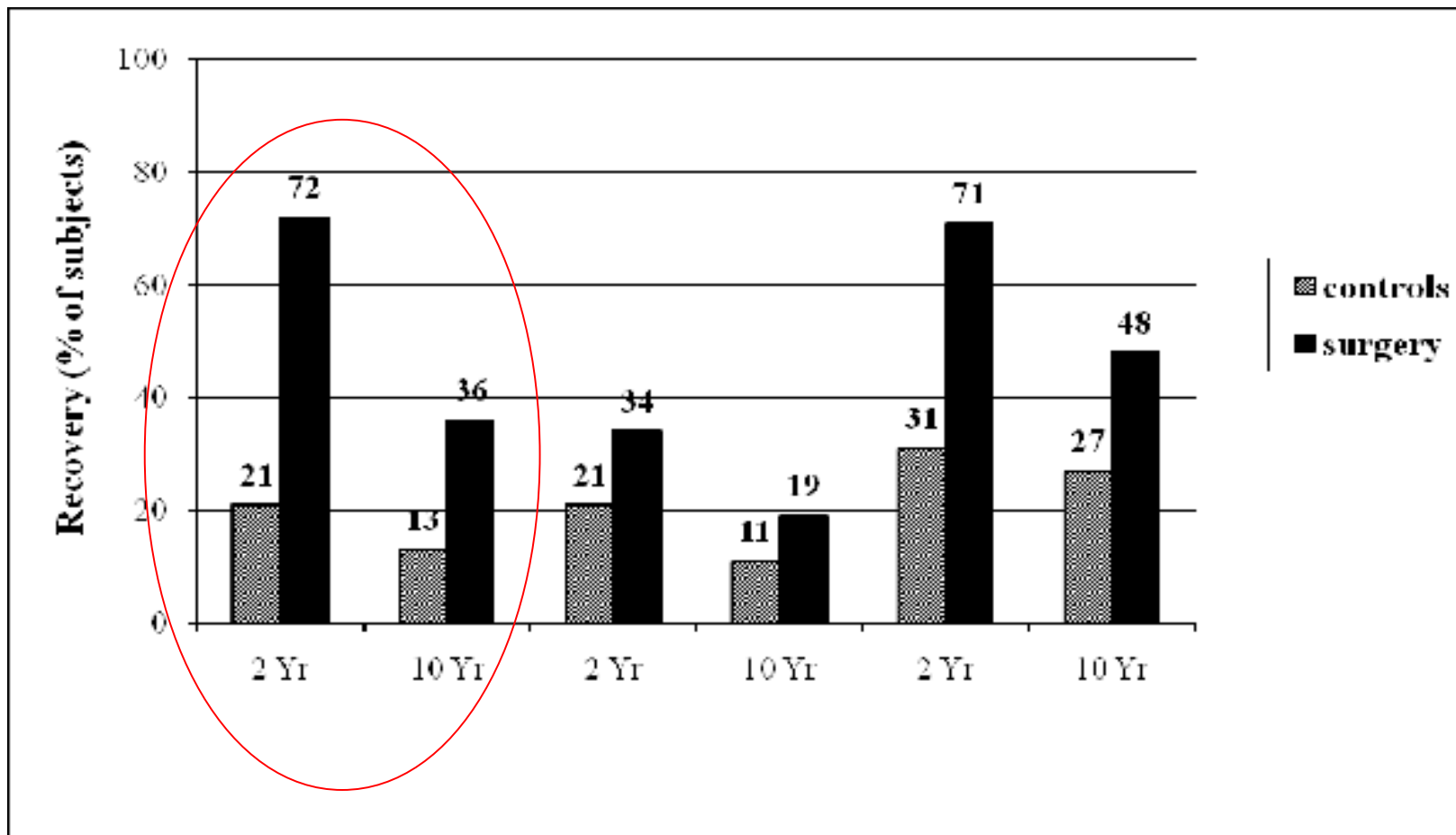


Lifestyle, Diabetes, and Cardiovascular Risk Factors 10 Years after Bariatric Surgery



Sjostrom et al. NEJM 2004;351:2683

Lifestyle, Diabetes, and Cardiovascular Risk Factors 10 Years after Bariatric Surgery



Sjostrom et al. NEJM 2004;351:2683

Effects of bariatric surgery on mortality in Swedish Obese Subjects.

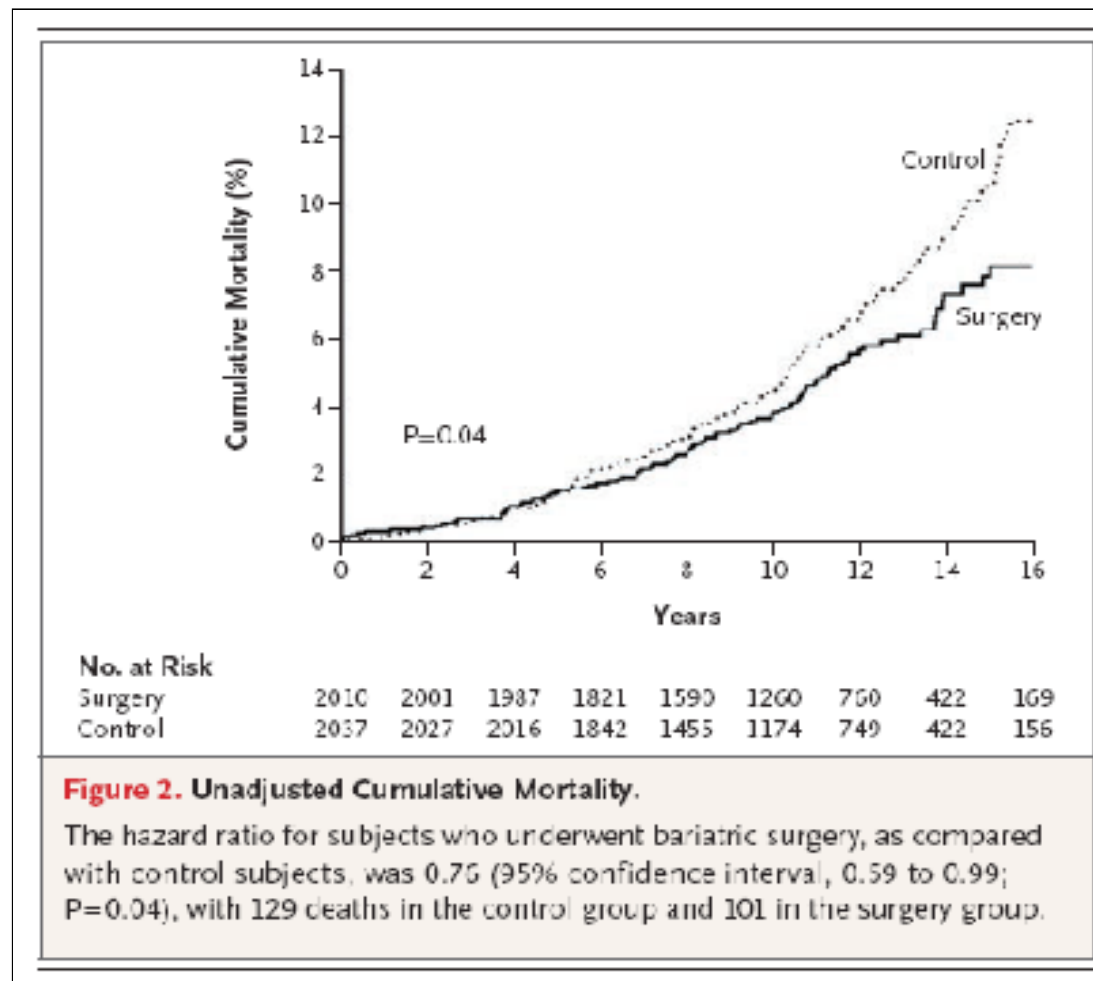


Table 2. Cause of Death.^a

Variable	Surgery Group (N=2010)	Control Group (N=2037)
no. of subjects		
Cardiovascular condition		
Any event	43	53
Cardiac	33	44
Myocardial infarction	13	25
Heart failure	2	5
Sudden death	20	14
Stroke	6	6
Intracerebral hemorrhage	2	4
Infarction	1	2
Subarachnoid bleeding	3	0
Other	2	3
Aortic aneurysm	1	2
Aortic thrombosis	0	1
Diabetic gangrene	1	0
Noncardiovascular condition		
Any event	58	76
Tumor	29	48
Cancer	29	47
Meningioma	0	1
Infection	12	3
Thromboembolic disease	5	7
Pulmonary embolism	4	7
Vena caval thrombosis	1	0
Other	12	18
Total no. of deaths	101	129

^a During the first 90 days after study initiation, there were five deaths in the surgery group (four from peritonitis with organ failure and one sudden death) and two deaths in the control group (one from cancer of the pancreas and one from alcohol-related causes).

Effects of bariatric surgery on cancer incidence in obese patients in Sweden (SOS Study).

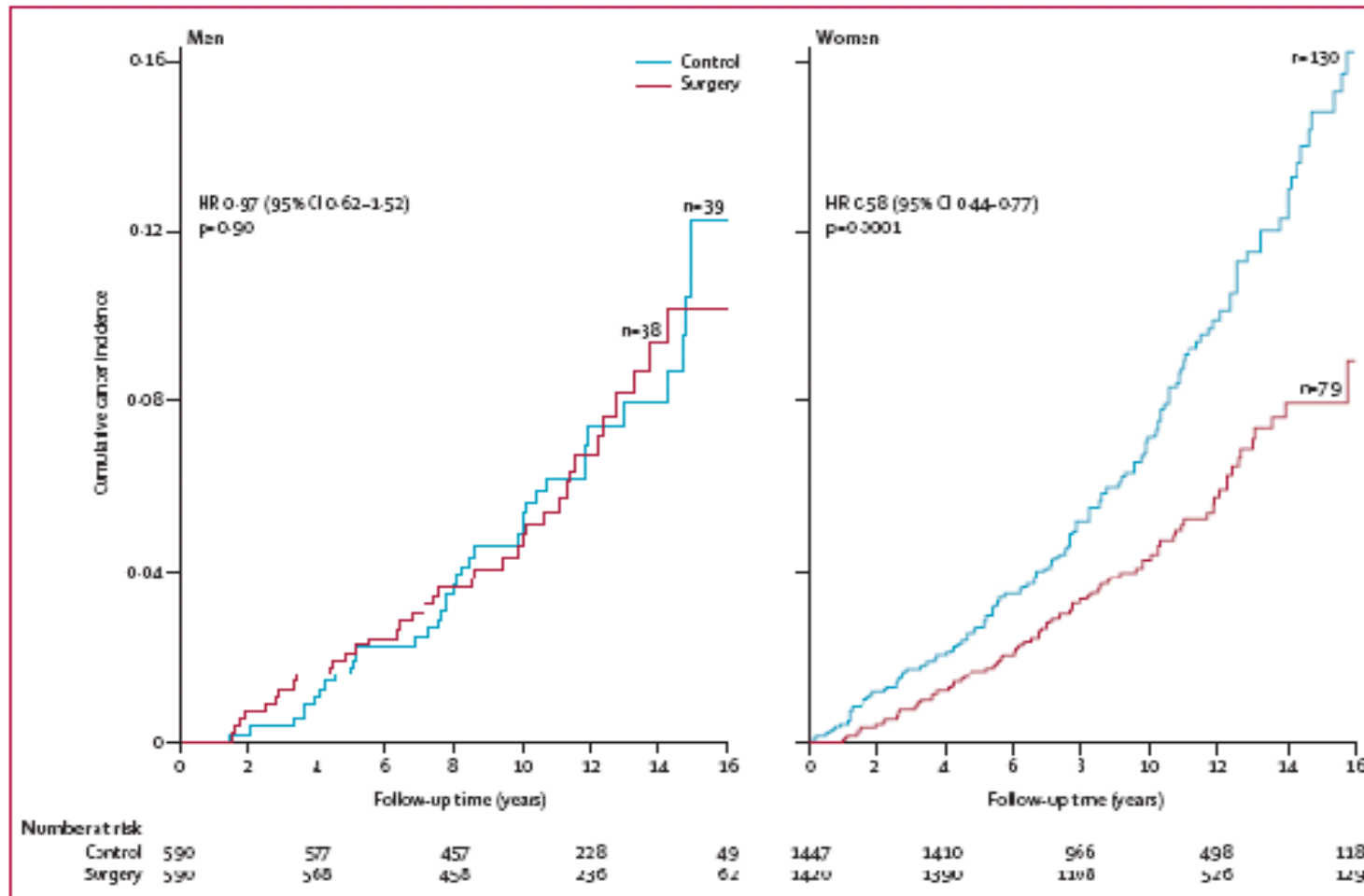


Figure 3: The unadjusted cumulative fatal plus non-fatal cancer incidence from the start of the intervention by sex in surgically treated obese individuals and in obese control individuals

Long term mortality after gastric bypass surgery.

Table 3. Hazard Ratios for Death in the Surgery Group as Compared with the Control Group.*

End Point	All Subjects		Matched Subjects	
	Hazard Ratio (95% CI)	P Value	Hazard Ratio (95% CI)	P Value
All causes of death	0.53 (0.53–0.74)	<0.001	0.50 (0.45–0.67)	<0.001
All deaths caused by disease	0.49 (0.41–0.59)	<0.001	0.48 (0.38–0.59)	<0.001
Cardiovascular disease	0.50 (0.36–0.69)	<0.001	0.51 (0.36–0.73)	<0.001
Coronary artery disease	0.36 (0.20–0.65)	<0.001	0.41 (0.21–0.78)	0.006
Heart failure	0.38 (0.08–1.82)	0.22	0.59 (0.11–3.15)	0.54
Stroke	0.52 (0.20–1.34)	0.18	0.43 (0.14–1.30)	0.14
Other cardiovascular disease	0.59 (0.38–0.89)	0.01	0.57 (0.35–0.91)	0.02
Diabetes	0.10 (0.02–0.46)	0.003	0.08 (0.01–0.47)	0.005
Cancer	0.38 (0.25–0.57)	<0.001	0.40 (0.25–0.65)	<0.001
Other diseases	0.55 (0.48–0.87)	0.005	0.55 (0.39–0.81)	0.002
All nondisease causes	1.76 (1.19–2.58)	0.004	1.58 (1.02–2.45)	0.04
Accident unrelated to drugs	1.34 (0.72–2.49)	0.36	1.22 (0.62–2.38)	0.56
Poisoning of undetermined intent	3.80 (1.29–12.0)	0.02	1.82 (0.51–6.54)	0.36
Suicide	1.71 (0.69–4.25)	0.25	2.03 (0.66–6.27)	0.22
Other nondisease cause	1.64 (0.82–3.28)	0.16	1.69 (0.75–3.82)	0.21

* Deaths that were caused by disease include all deaths minus those caused by accidents unrelated to drugs, poisonings of undetermined intent, suicides, and other nondisease deaths. Hazard ratios were adjusted for sex, age, and corrected body mass index.

Adjustable gastric banding and conventional therapy for type 2 diabetes: a randomized controlled trial.

Table 2. Primary and Secondary Outcomes at 2 Years^a

Variable	Mean (SD)		Between-Group Difference, Mean (95% CI)	P Value
	Surgery (n = 30)	Conventional Therapy (n = 30)		
Primary Outcome, No. (%)				
Remission of diabetes, No. (%)	22 (73)	4 (13)	RR for surgical remission, 5.5 (2.2 to 14.0)	<.001
Secondary Outcomes				
Weight, kg	84.6 (15.8)	104.8 (15.3)		
Change, kg	-21.1 (10.5)	-1.5 (5.4)	-19.6 (-23.8 to -15.2)	<.001
Waist circumference, cm	95.8 (10.3)	112.7 (10.3)		
Change, cm	-17.9 (10.8)	-4.0 (9.1)	-13.9 (-19.0 to -8.7)	<.001
Waist to hip ratio	0.90 (0.09)	0.95 (0.08)		
Change	-0.09 (0.09)	-0.01 (0.09)	-0.08 (-0.07 to -0.007)	.02
Blood pressure, mm Hg				
Systolic	130.4 (19.0)	132.6 (17.7)		
Change	-6.0 (17.9)	-1.7 (14.2)	-4.3 (-13.6 to 5.1)	.37
Diastolic	65.4 (7.0)	66.1 (6.5)		
Change	-0.7 (11.1)	-0.9 (11.1)	0.2 (-5.4 to 5.0)	.92
HbA _{1c} , %	6.00 (0.82)	7.21 (1.39)		
Change	-1.81 (1.24)	-0.38 (1.26)	-1.43 (-2.1 to -0.60)	<.001
Plasma glucose, mg/dL	105.6 (30.3)	139.6 (38.1)		
Change	-51.2 (37.6)	-18.4 (41.2)	-32.8 (-53.1 to -12.3)	.002
Plasma insulin, µU/mL	9.9 (4.7)	24.1 (13.6)		
Change	-12.4 (6.4)	1.0 (14.8)	-13.4 (-19.6 to -7.3)	<.001
HOMA-IR ^b	1.90 (0.73)	3.50 (0.97)		
Change, %	-45.5 (19.0)	-3.3 (35.4)	-42.2 (-57 to -26.8) ^c	<.001
Total cholesterol, mg/dL	205.4 (48.6)	197.8 (59.3)		
Change	3.6 (51.6)	-0.4 (31.4)	4.0 (-18.6 to 26.0)	.72
Triglycerides, mg/dL	118.9 (79.7)	156.7 (127.2)		
Change	-71.7 (62.6)	-2.1 (120.0)	-69.6 (-125.3 to -13.9)	.02
HDL-C, mg/dL	59.7 (13.6)	50.7 (12.1)		
Change	12.6 (6.8)	2.6 (6.1)	10.0 (5.8 to 14.2)	<.001
Total cholesterol to HDL-C ratio	3.58 (1.03)	4.1 (1.8)		
Change	-0.82 (1.0)	-0.14 (1.04)	-0.68 (-1.24 to -0.14)	.02



Abbreviations: CI, confidence interval; HbA_{1c}, glycated hemoglobin; HDL-C, high density lipoprotein cholesterol; HOMA-IR, insulin resistance by homeostatic model assessment; LDL-C, low density lipoprotein cholesterol; RR, relative risk; SE, standard error; see Table 1 footnote.

^aMean (SD) percentage change for participants with baseline values carried forward for those who dropped out of the study. A comparison of the actual change from baseline is also presented. Data include all 60 participants with baseline data carried forward for missing data.

^bAn indirect measure of insulin resistance calculated from levels of fasting plasma glucose and fasting C-peptide.²⁶

^cP < .05 calculated using independent t test.

Dixon et al. JAMA 2008;299:316

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Total cholesterol to HDL-C ratio	3.58 (1.03)	4.1 (1.8)		
Change	-0.82 (1.0)	-0.14 (1.04)	-0.68 (-1.24 to -0.14)	.02

Abbreviations: CI, confidence interval; HbA_{1c}, glycated hemoglobin; HDL-C, high density lipoprotein cholesterol; HOMA-IR, insulin resistance by homeostatic model assessment; LDL-C, low density lipoprotein cholesterol; RR, relative risk; SE, standard error; CI, confidence interval.

^aMean (SD) percentage change for participants with baseline values carried forward for those who dropped out of the study. A comparison of the actual change from baseline is also presented. Data include all 60 participants with baseline data carried forward for missing data.

^bAn indirect measure of insulin resistance calculated from levels of fasting plasma glucose and fasting C-peptide.²⁸

^cP < .05 calculated using independent t test.



Dixon et al. JAMA 2008;299:316

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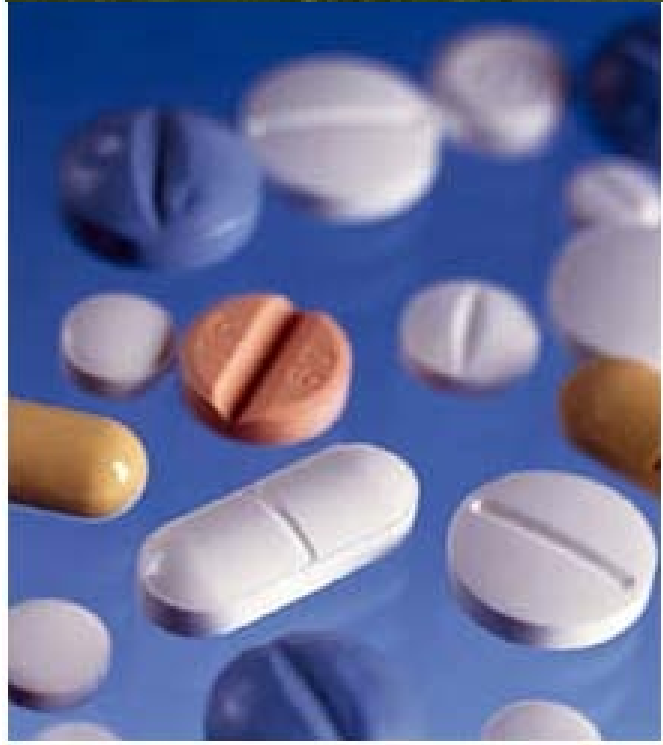
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non tutti gli anti-
diabetici,
non tutti gli anti-
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non tutti i farmaci.....
sono uguali.



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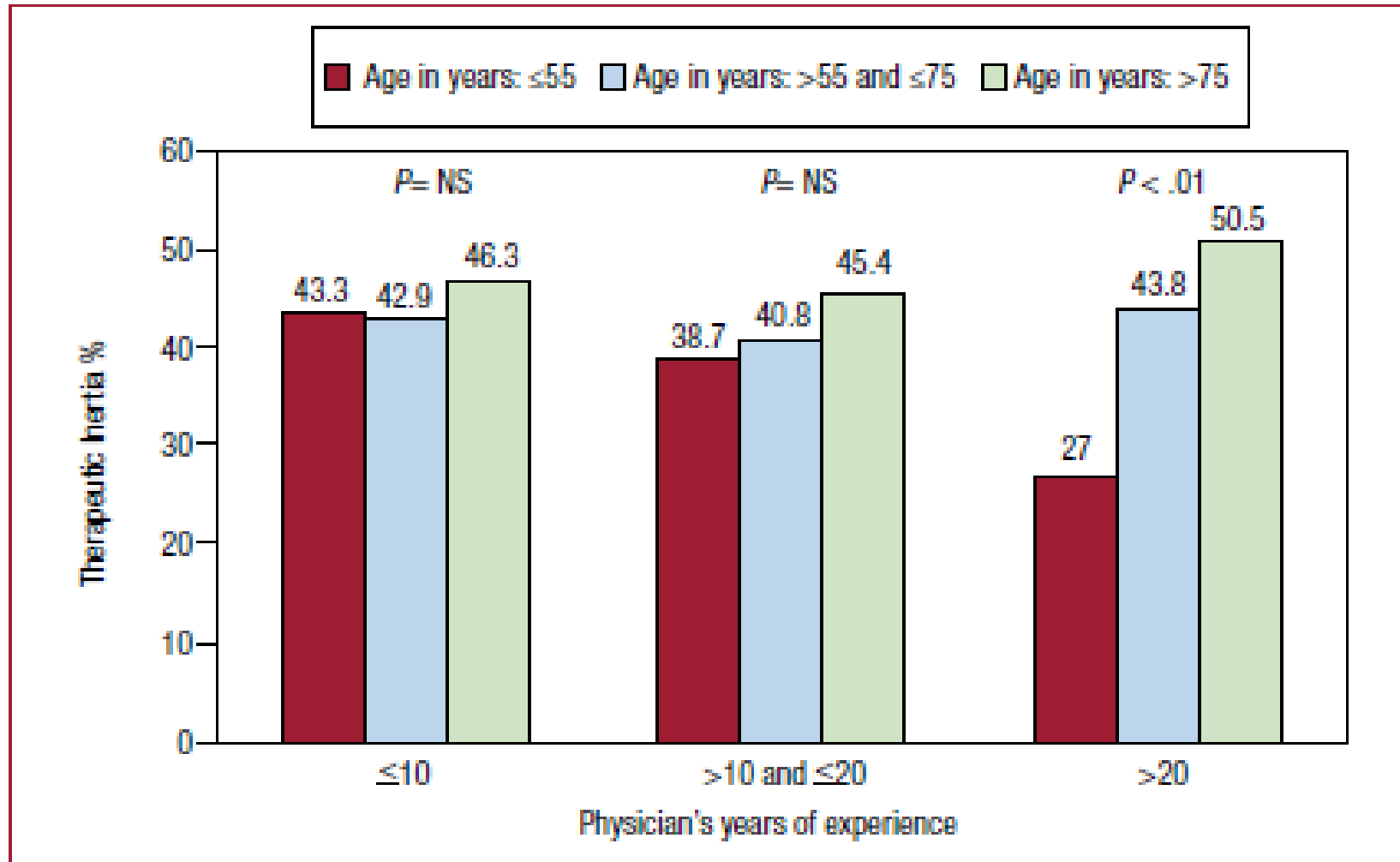


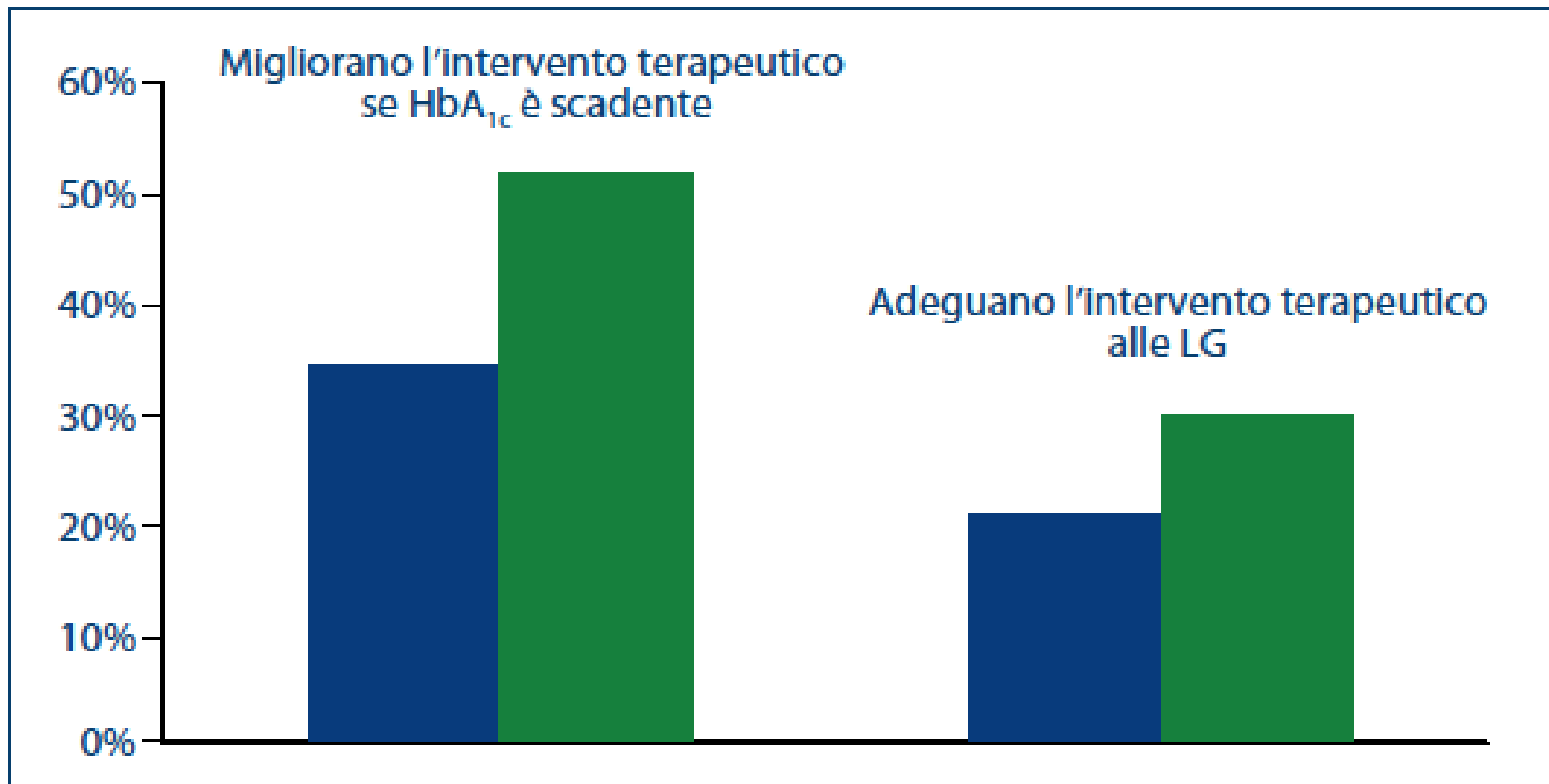
Tabella I. Raccomandazioni per ridurre il fenomeno dell'inerzia clinica (da Phillips et al., 2001).

Frequenti aggiornamenti sulle linee guida
Corsi a tutti i livelli (specialisti, medici di famiglia, specializzandi) sul pericolo dell'inerzia terapeutica
Formazione universitaria meno teorica, più focalizzata sulla efficacia della pratica clinica
Revisione sistematica del proprio operato
Uso di cartelle cliniche informatizzate con "reminders" che migliorino la prestazione clinica
Incontri regolari con colleghi per valutazione dell'attività clinica

Therapeutic Inertia in the Outpatient Management of Dyslipidemia in Patients With Ischemic Heart Disease. The Inertia Study

Pablo Lázaro,^a Nekane Murga,^b Dolores Aguilar,^a and Miguel A. Hernández-Presa^c on behalf of the INERTIA Study investigators





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Miglioramento dell'inerzia terapeutica in 345 medici sottoposti a un programma di 3 anni di formazione e verifica dei risultati (da Ziemer et al., 2006)

COME PUO' AGIRE IL MEDICO



**Ricercando
il fenomeno
nella propria
realta`**

**Riconsiderando
eventuali ragionamenti
"scusa" che insorgono
nel momento
di prendere decisioni
terapeutiche**

**Rivedendo
periodicamente
il proprio operato
(audit)
e confrontandosi
con i colleghi**

In the present, however, data are messy and it is up to physicians to interpret and implement data in a way that benefits patients the most.

While inaction may sometimes be the best option, more often physicians should act but do not.

Ignoring the best available evidence is rarely the best approach.

Arun V. Mohan, MD, MBA
Lawrence S. Phillips, MD