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Clinical Inertia: A Wakeup Call for Healthcare Professionals

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Editorial

Prevalence of diabetes is increasing worldwide and has become a major public health problem. Diabetes is associated with various complications including chronic complications like micro vascular and macro vascular disease which are associated with high morbidity and mortality and result in poor quality of life and economic burden to the individual and to the society. Various landmark studies proved it beyond doubt that strict glycemic control drastically reduces diabetes related complication. Based on this observation various International bodies emphasize the concept of treating to target.

In the recent years there are major development in the field of diabetes management and technologies supporting diabetes care. We have DPP- 4 inhibitors, GLP-1analogues and SGLT-2 inhibitors added to the armamentarium of Anti Diabetic medications recently. Metabolic surgery is emerging as a curative therapy in patients with disability. Insulin pump can simulate normal physiological insulin release, helping to achieve smooth glycaemic control. Advanced monitoring technologies like continuous glucose monitoring help us to assess the adequacy of glycemic control and reduce glycemic variability. But if we analyse the real world data it is disappointing that only a minority of the patient with Diabetes achieve strict glycemic control. Poor glycemic control results in increased incidence of diabetes related complications adding to increased morbidity and mortality, which also cause substantial economic burden. This can be effectively reduced by proper diabetic management. Inability to achieve tight glycemic control in real world practice can be due to various factors. Health care provider has got important role in helping people with diabetes to achieve target in glycemic control. Inability of the healthcare professional to initiate or intensify treatment appropriately is called clinical inertia, which is an important contributor to poor glycemic control [1]. Clinical inertia can be inertia in initiating treatment or inertia in up titrating the dose of the medicine when it is indicated in a timely manner.

In a population based survey it was found that 41.4 %of diabetic patients are having HbA1c of more than 8% showing the inability to attain glycemic target in a large number of individuals with diabetes [2]. Another study showed that only half of the patients with diabetes meet the target glycemic control and only one third of hypertensive and one fourth of dyslipidemic patients achieve the treatment target showing the magnitude of the problem [3]. Inadequate control of blood sugar level can lead to various short and long term complications in patients with diabetes. In type 2 diabetes patients with HbA1c of ≥7% who failed to receive treatment intensification within a year experienced an increased risk of myocardial infarction, stroke, heart failure, and combined cardiovascular end points, indicating the importance of timely up titration of anti-diabetic treatment [4].

Clinical inertia can be inability to start or intensify OAD (Oral Anti-Diabetic agents) or insulin in a timely manner when it is indicated. In a study it was found that mean HbA1c on insulin initiation is 9.7% in patients on 3 OAD and the time delay in insulin initiation is more than 6 years [5].

The factors leading to clinical inertia can be related to health care provider, patient, or the social factors. The clinicians concern regarding side effects especially the risk of hypoglycemia results in delay in intensification of anti-diabetic therapy. Patients attitude, non-adherence, financial constraints, lack of time for efficient communication are other important factors contributing to this. Empowering the clinician with adequate knowledge and motivation will help to tackle the issue of clinical inertia thereby helping to achieve the treatment targets, which substantially reduce diabetes related complications and economic burden. Clinical inertia actually prevents the achievement of benefits of diabetic therapy observed in various clinical trials into real world scenario. But we must always balance over aggressiveness to tackle clinical inertia with the risks of overtreatment and hypoglycemic risk especially in elderly individuals, where individualization of treatment target is important.

Improving the knowledge and experience to treat diabetes and adherence to standard guidelines will help the clinician to overcome clinical inertia. We must tackle the issue of clinical inertia in order to transfer the benefits of glycemic control observed in clinical trials into a real life scenario.

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