

WHY DON'T WE FOLLOW EVIDENCE-BASED GUIDELINES?

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In this issue of *JLGH*, we are pleased to highlight provocative work being done at LG Health, including a report from Meredith Clark and her Pharmacy Services colleagues. They present results of a review they performed on the charts of patients who have both diabetes and some form of cardiovascular disease. Notably, more than 25% of these charts had no evidence that patients had received a prescription for SGLT-2 inhibitors or GLP-RAs, medications recommended by the American Diabetes Association.

Certainly, this is not a problem unique to Lancaster. In a systematic review of 54 studies, most patient-practitioner dyads needed more than a year to accelerate therapy when labs confirmed that patients were not at therapeutic goal regarding their diabetes.¹ What is notable in Clark's report is that the local study documented non-adherence over more than three years.

The concept of clinical inertia – the failure to accelerate or otherwise change therapy to meet the standard of care – was first described in the literature more than 20 years ago,² and we have all certainly taken note of this occurrence at times in a patient chart. But now with the use of the electronic medical record and chart mining, we can readily detect this propensity at scale. Add in big data, and we're faced with big questions, notably: Why don't we, as partners in the health care experience, follow guidance?

Clinical inertia is the result of factors at the level of the clinician, the patient, and the clinic in general. At the clinician level, there may be lack of awareness or know-how, lack of understanding regarding need, or confusion regarding conflicting suggestions. We all have competing demands, but certainly most have a bias toward "doing no harm."

At the patient level, there may also be a lack of insight, a comfort regarding current plan-of-action or goals, and an emotional overlay we might broadly call fear. Yet there is some evidence that health care professionals inappropriately lay blame; patient frustrations with the health care labyrinth are not necessarily representative of a lack of interest in change.³

Finally, the system may be part of the challenge, for example if the clinical care team isn't helping to facilitate change, if there are medicine supply short-

ages or insurance barriers, among other possibilities. As clinicians we may all feel we lack the tools to build the plane we're flying.

Of course, process evaluations – like the one presented by Clark and her colleagues – must eventually be translated into formative interventions so that the promise of health system learning processes can be realized. An intervention need not be complex; studies of clinical inertia in hyperlipidemia suggest that patients who know their targets are more likely to achieve their goals.⁴

So, how can we reduce the risk for clinical inertia? Working closely with those who question the status quo – like students and residents – and conducting projects and making presentations – like doing studies and publishing articles – will bring us closer to not only practice guidelines, but how we may better serve our patients. Studies also demonstrate that targeted guidance and ongoing peer review help physicians better follow standards.^{5,6}

We at LG Health are fortunate to have unique resources available, from the Research Institute and Business Intelligence partners, to the Center for Healthcare Innovation, all of which can help us with implementation science. Thus, structural change is within reach.

Clinical inertia may be putting patients at risk, but our own medical education represents a continuous opportunity. I hope what you find in these pages can help inspire better care.

REFERENCES

1. Khunti K, Gomes MB, Pocock S, et al. Therapeutic inertia in the treatment of hyperglycaemia in patients with type 2 diabetes: a systematic review. *Diabetes Obes Metab*. 2018;20(2):427-437.
2. Phillips LS, Branch WT, Cook CB, et al. Clinical inertia. *Ann Intern Med*. 2001;135(9):825-834.
3. O'Connor PJ, Sperl-Hillen JAM, Johnson PE, et al. Clinical inertia and outpatient medical errors. In: Henriksen K, Battles JB, Marks ES, et al., eds. *Advances in Patient Safety: From Research to Implementation (Volume 2: Concepts and Methodology)*. Agency for Healthcare Research and Quality (US); 2005. Accessed February 18, 2024. <https://www.ncbi.nlm.nih.gov/books/NBK20513/>
4. Ogura M, Harada-Shiba M. Clinical inertia in the management of hypercholesterolemia: what clinicians need to do. *J Atheroscler Thromb*. 2016;23(5):552-553.
5. Goldberg KC, Melnyk SD, Simel DL. Overcoming inertia: improvement in achieving target low-density lipoprotein cholesterol. *Am J Manag Care*. 2007;13(9):530-534.
6. Fiscella K, Volpe E, Winters P, Brown M, Idris A, Harren T. A novel approach to quality improvement in a safety-net practice: concurrent peer review visits. *J Natl Med Assoc*. 2010;102(12):1231-1236.