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Breaking of status QUO: Overcoming clinical inertia in sexual medicine practice

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INTRODUCTION

- Clinical inertia
- Importance of CI
- CI in sexual medicine practice
- Factors contributing to CI
- How to tackle clinical inertia
- Conclusion

Clinical inertia

- Inability or failure of health care providers to initiate or intensify therapy when it is actually indicated

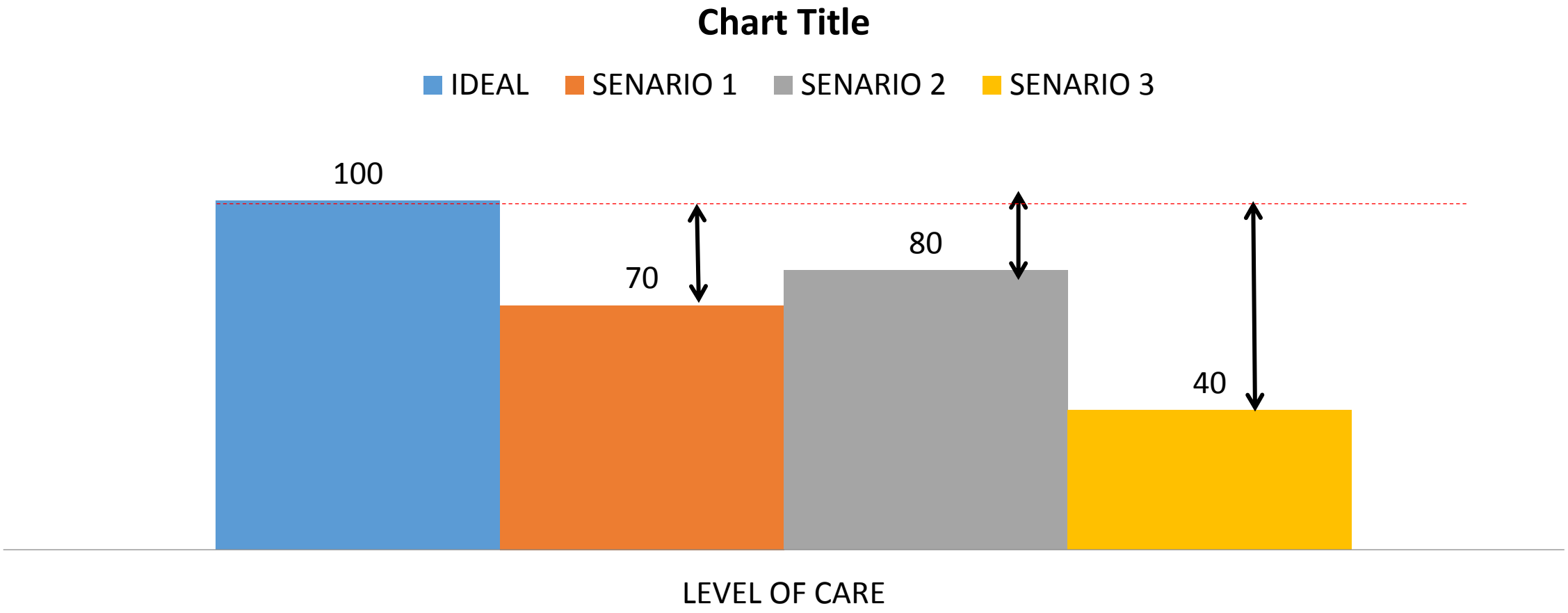
Ref: Phillips LS, Branch WT, Cook CB, et al. Clinical inertia. Ann Intern Med. 2001;135(9):825-34

Clinical inertia

- It is an evidence practice gap
- An evidence practice gap is defined as the ‘difference between what we know from best available research evidence and what actually happens in current practice’

Ref : National Institute of Clinical Studies. Evidence-Practice Gaps Report, Volume 1. NICS, Melbourne, 2003. Available at www.nhmrc.gov.au/nics/material_resources/resources/evidence_volume_one.htm [Accessed 4 September 2010].

Clinical inertia



The gap between the best current practice recommendation and the level of care the patient received

Clinical inertia

- “recognition of the problem, but failure to act”

Ref: Phillips LS, Branch WT, Cook CB, et al. Clinical inertia. Ann Intern Med. 2001;135(9):825-34

Clinical inertia

- “recognition of the problem, but failure to act”
- In people with suboptimal disease control, if one is adding an agent which is unlikely to achieve the recommended treatment target, then that also contributes to clinical inertia.
- “recognition of the problem, but failure to act appropriately”

Ref: Byrnes PD. Why haven’t I changed that? Therapeutic inertia in general practice. Aust Fam Physician. 2011;40(1–2):24-8.

Clinical inertia

- The term “clinical inertia” was first coined by Phillips et al in 2001
- Okonufa et al. introduced the terms “therapeutic inertia” in 2006
- Various terms like “therapeutic inertia”, “physician inertia”, and “diagnostic inertia” are synonymously used with clinical inertia
- But strictly speaking they are only subdivisions of clinical inertia

Definition

- Diagnostic inertia : Diagnostic inertia was defined as a failure to consider the diagnosis

Ref: Gil-Guillén et al.. Blood Press 2010, 19:3–10.

Definition

- Therapeutic inertia : failure of providers to begin new medications or increase dosages of existing medications when an abnormal clinical parameter is recorded.

Ref: Okonufa et al.. Hypertension 2006, 3:345–351.

Clinical inertia

- Clinical inertia also may apply to the failure of physicians to stop or reduce therapy which is no longer required

Reverse clinical inertia

Ref:

Clinical inertia

- Failure to de-intensify therapy when appropriate

FRAIL DIABETES PHENOTYPE

- Elderly
- Underweight
- Long duration of diabetes
- Underlying heart disease or stroke
- Renal insufficiency

Ref: Khunti K, Davies MJ. Primary care diabetes. 2017;11:105-106

"Therapeutic dragging"

Another type of therapeutic inertia

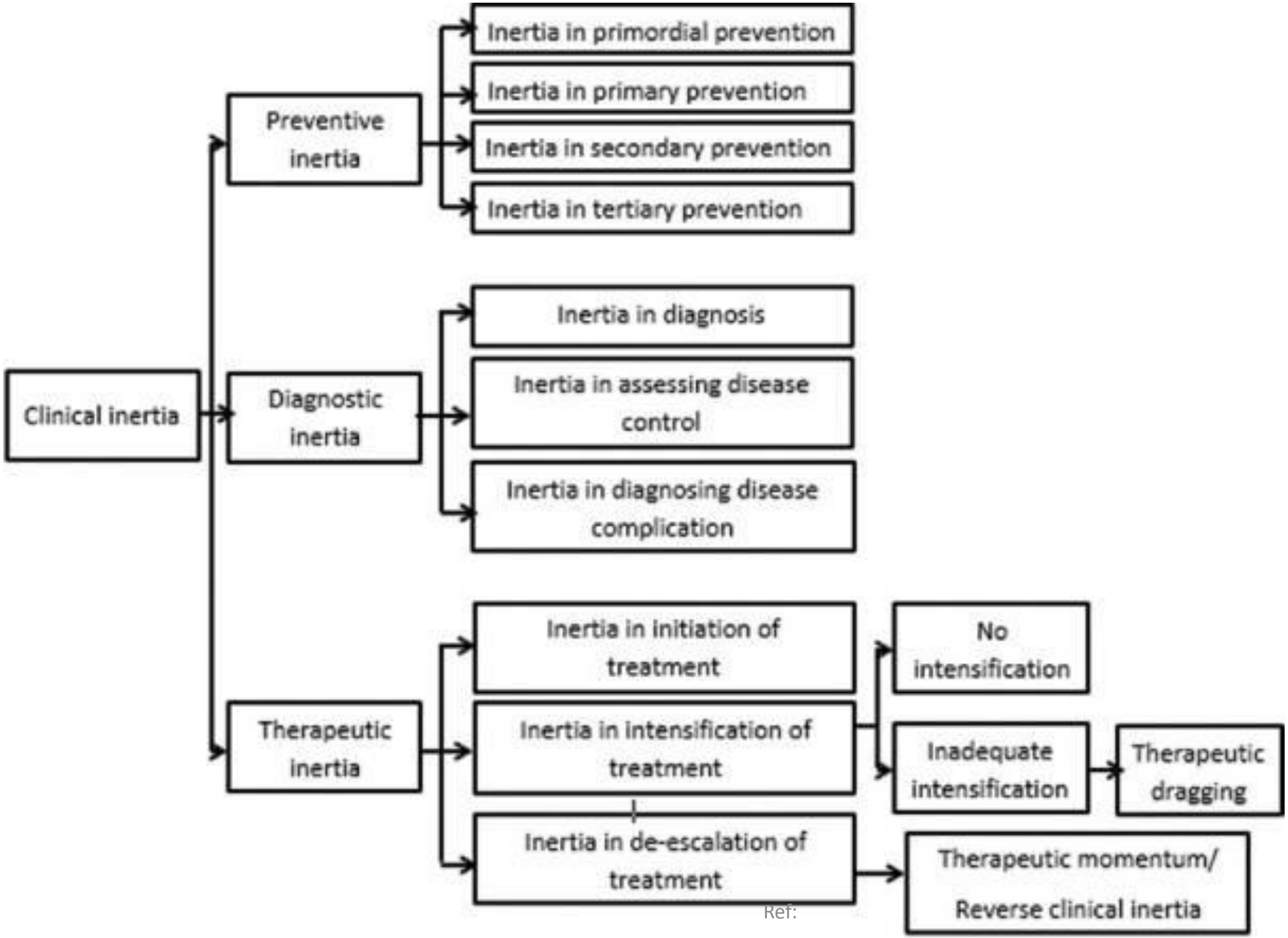
Intensification or escalation of treatment when the therapeutic target is not achieved

But is inadequate and insufficient to attain the therapeutic target

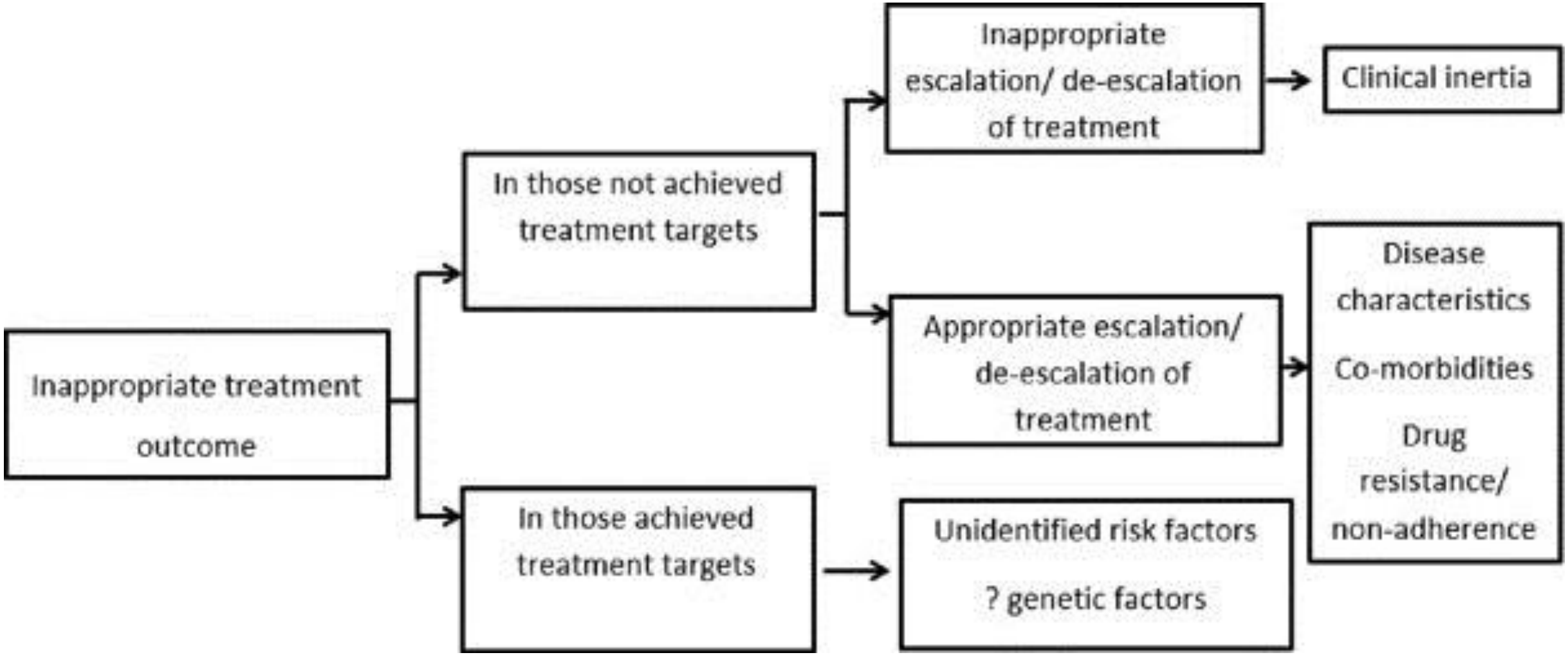
Without further intensification in a stipulated time period

"recognition of the problem, but inadequate action"

Ref.


Clinical inertia
Preventive inertia
Inertia in primordial prevention
Inertia in primary prevention
Inertia in secondary prevention
Inertia in tertiary prevention
Diagnostic inertia
Inertia in diagnosis
Inertia in assessing disease control
Inertia in diagnosing disease complication
Therapeutic inertia
Inertia in initiation of treatment
Inertia in intensification of treatment
Inertia in de-escalation of treatment
No intensification
Inadequate intensification
Therapeutic dragging
Therapeutic momentum/ Reverse clinical inertia

Ref:


Inappropriate treatment outcome
In those not achieved treatment targets
In those achieved treatment targets
Inappropriate escalation/ de-escalation of treatment
Clinical inertia
Appropriate escalation/ de-escalation of treatment
Disease characteristics
Co-morbidities
Drug resistance/ non-adherence
Unidentified risk factors
? genetic factors

Ref:

Therapeutic inertia: proposed classification criteria

Therapeutic action criteria

- Undue delay to initiate treatment
- Undue delay to escalate treatment
- Undue delay to de-escalate treatment

Duration criteria

- Within a defined time period for a particular disease

Therapeutic inertia outcome criteria

- Failure to attain the therapeutic target
- Progression of the disease process
- Development of disease complications
- Development of drug-related complications
- Development of overtreatment-related complications

Ref:

Therapeutic inertia: proposed classification criteria

Therapeutic "gold standard" criteria

- There is a well-established treatment guideline and therapeutic targets
- There is clear evidence of the benefit of therapy
- There is clear evidence of the benefit of attainment of treatment targets

Basic requirement criteria

- The mentioned treatment facility is available, accessible, acceptable, and affordable

Exclusion criteria

- The therapeutic target relaxed in view of patient profile and associated co-morbidities/disease/complications

Ref:

Clinical inertia in sexual medicine practice

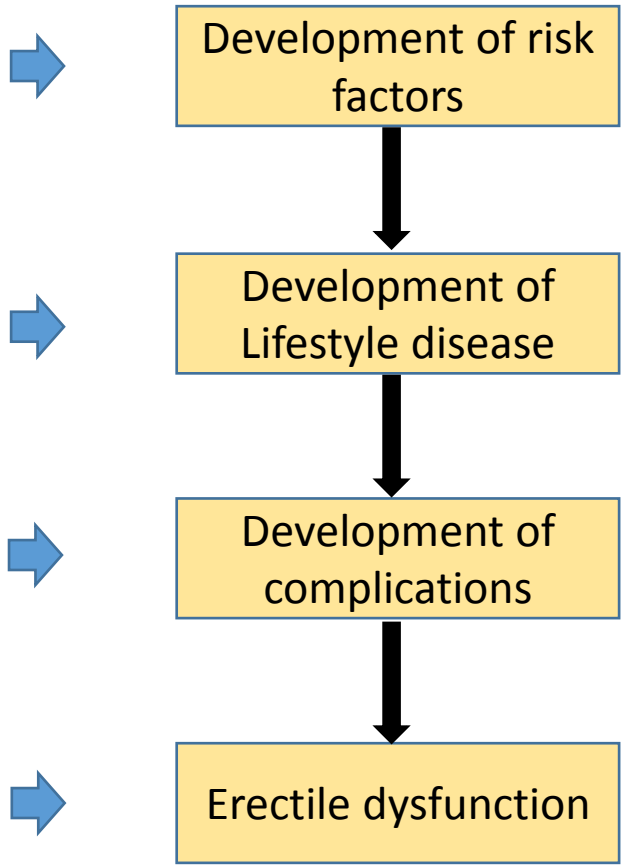
- Clinical inertia is widespread in sexual medicine practices
- There is significant delay in diagnosing and treating various sexual health issues
  - because of the stigma associated with sexual health problems
- in addition to other usual causes of clinical inertia

Preventive Inertia

- Inertia in preventing the development and progression of sexual dysfunction constitutes preventive inertia.

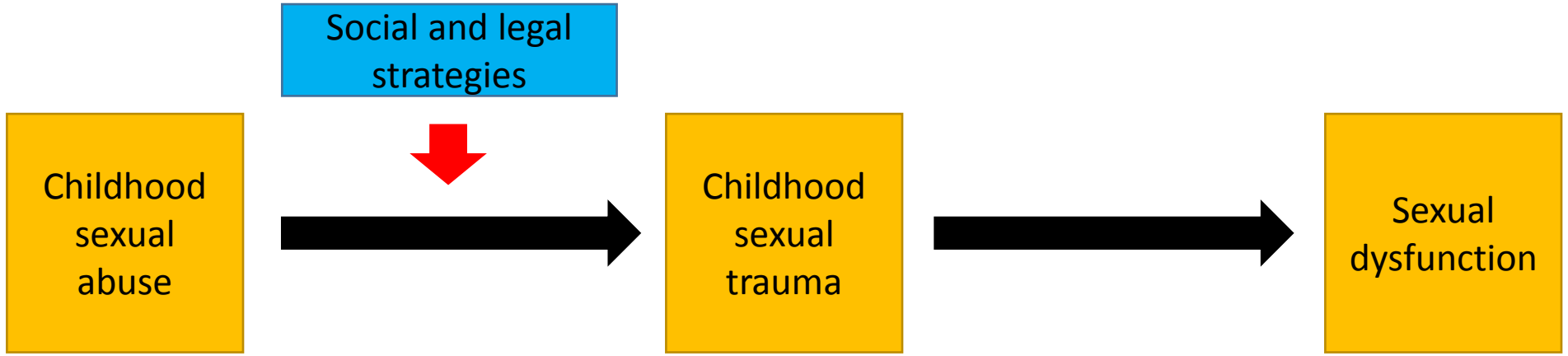
Preventive Inertia

- The classic example is erectile dysfunction (ED) due to atherosclerotic vascular disease
  - Delay in preventing the development of lifestyle diseases like obesity, diabetes, hypertension, and dyslipidemia
  - Delay in preventing the progression of these lifestyle disorders in those who already have it
- Constitutes preventive inertia in the development of ED



Preventive Inertia

- Childhood sexual trauma and sexual abuse can lead to vaginismus in women. Social and legal strategies to prevent childhood sexual abuse help to prevent the development of vaginismus.
- Our inertia in properly implementing these can lead to various sexual dysfunctions (SD) associated with childhood sexual trauma. This is an example of inertia at the community level in preventing SD.

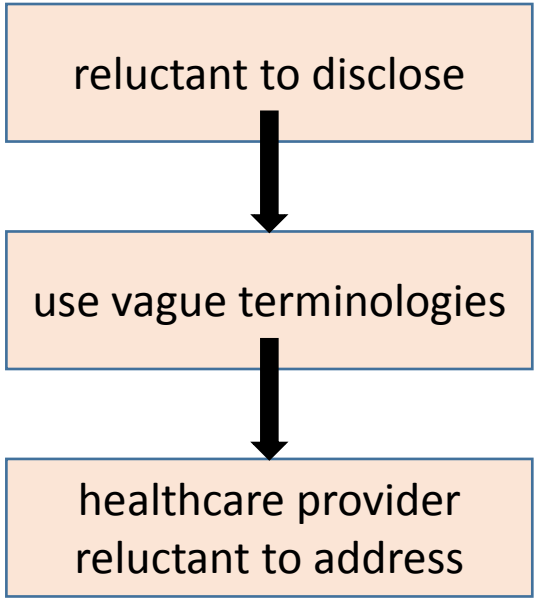


Diagnostic Inertia

- Diagnostic inertia is prevalent in sexual medicine practice

Diagnostic Inertia

- People with sexual dysfunction are **reluctant to disclose** their sexual problems because of the associated stigma
- Even if they disclose, they **use vague terminologies** to express their sexual health issues
- For example, people with ED may say that they are feeling excessive tiredness, or weakness denoting ED, which may be difficult to recognize especially in a busy outpatient department
- Similarly, even if the patient says that he is having ED, the **healthcare provider** most of the time prescribes some multivitamins without properly paying attention and without proper evaluation of SD



Therapeutic Inertia

- Inertia in initiating treatment of sexual health issues is very common in day-to-day clinical practice.
- Clinicians are reluctant to discuss sexual health issues most of the time with the patient, even if the patient discloses their sexual problems, leading to barriers in the evaluation and specific management of sexual problems
- Most of the time, healthcare providers buy time by prescribing multivitamins, antioxidants, or other placebos instead of doing a proper evaluation and starting specific treatment for SD

Inertia in addressing co-morbidities and complications

- Associated co-morbidities and complications need to be addressed properly for optimal benefits in sexual medicine practice also, as with any other branch of medicine.
- ED is considered a forerunner of future cardiovascular events as people with atherosclerotic ED, develop cardiovascular events 3-5 years after the onset of ED
- Hence treating ED without addressing the cardiovascular risk factors is a classic example of inertia in addressing the associated co-morbidities and complications

STAGES OF CONSULTATION	FACTORS CONTRIBUTING TO CLINICAL INERTIA
1 Recognition of sexual health issues by the person	• Person think that it is part of ageing
2 Decision to consult healthcare professional for sexual dysfunction	• Stigma associated with sexual problem • False belief that there is no effective treatment for sexual dysfunction
3 Consultation with health care professionals	• Patient using vague terms to describe sexual problems • Health care professionals reluctance to ask more about sexual dysfunction • Health care professionals attitude towards sexual health problem • Health care professionals knowledge and experience about management of sexual dysfunction
4 Treatment of sexual dysfunction	• Lack of proper referral system and specialist care • Cost of therapy • Failure to identify and control risk factors and co-morbidities
5 Follow up of people with sexual dysfunction	• People think that one time therapy is the solution for sexual problems • Failure to control risk factors and co morbidities

Factors contributing to Clinical Inertia

- Factors contributing to CI can be divided into
    - Physician or provider-related
    - Patient-related
    - System-related

Factors contributing to Clinical Inertia

- Patient related factors
  - The stigma associated with sexual health issues
  - Embarrassment
  - Discomfort in discussing sexual issues

Factors contributing to Clinical Inertia

- Healthcare providers related factors
  - Embarrassed to discuss sexual issues
  - Fearing that asking about sexual health issues may lead to the loss of patients from their practice
  - Lack of proper training about sexual health issues in the medical curriculum
  - Lack of confidence in dealing with sexual health issues
  - Busy OPD
  - Lack of time
  - Lack of support
  - Lack of availability of a multidisciplinary team and referral for specialist care,
  - Provider’s inability to provide appropriate care
  - Ambiguity in the existing guidelines

Factors contributing to Clinical Inertia

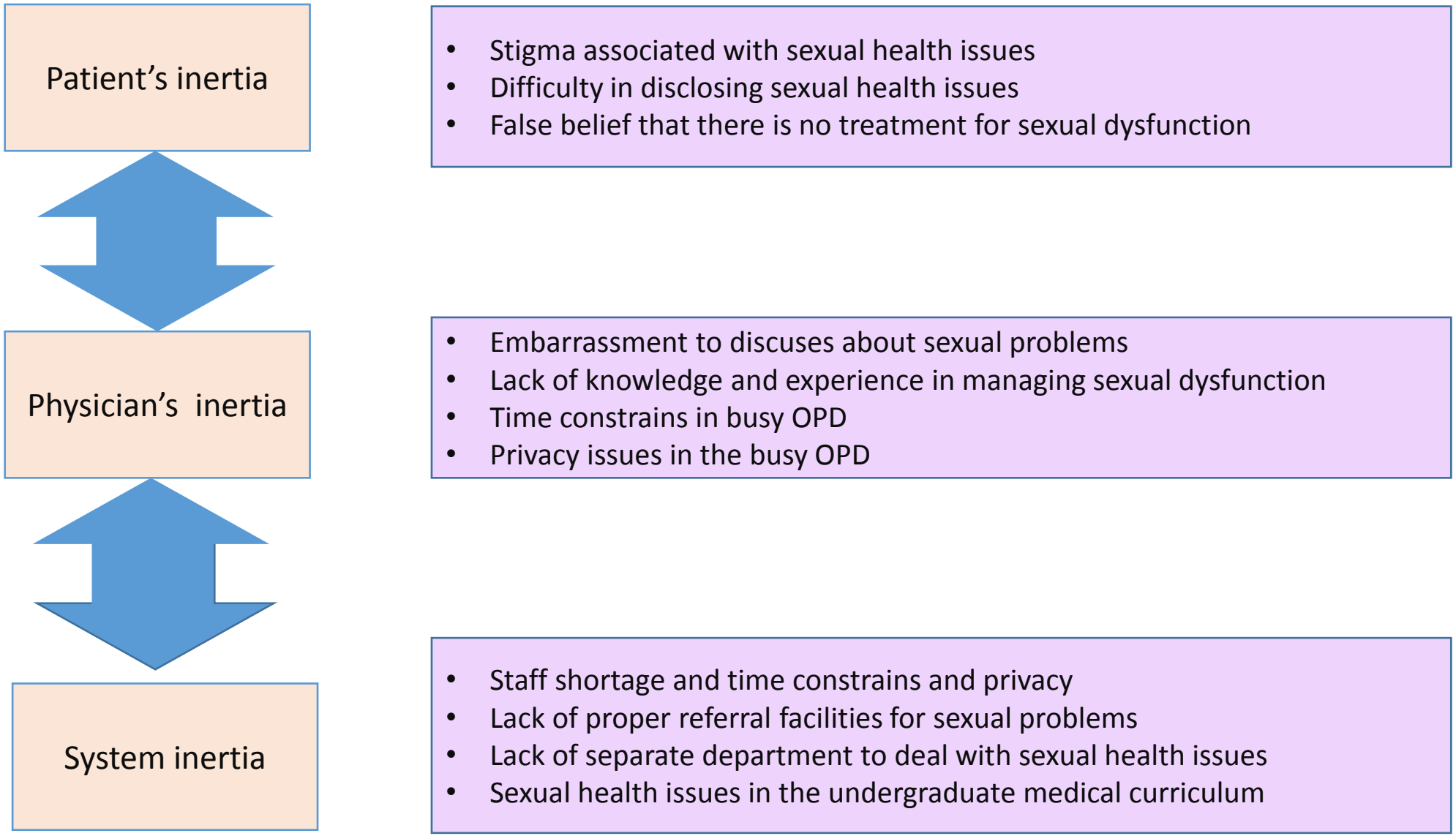
- Patient characteristics
  - Patients with other comorbid diseases like CAD, heart failure
  - Patients on polypharmacy
  - Quality of the relationship between patient and health care provider
  - Concern about adverse reactions or drug interaction
  - Health literacy
  - Socio-economic status of the patient
  - Affordability
  - Patient attitudes and preferences
  - lack of communication between patient and physician
  - Non-adherence to treatment

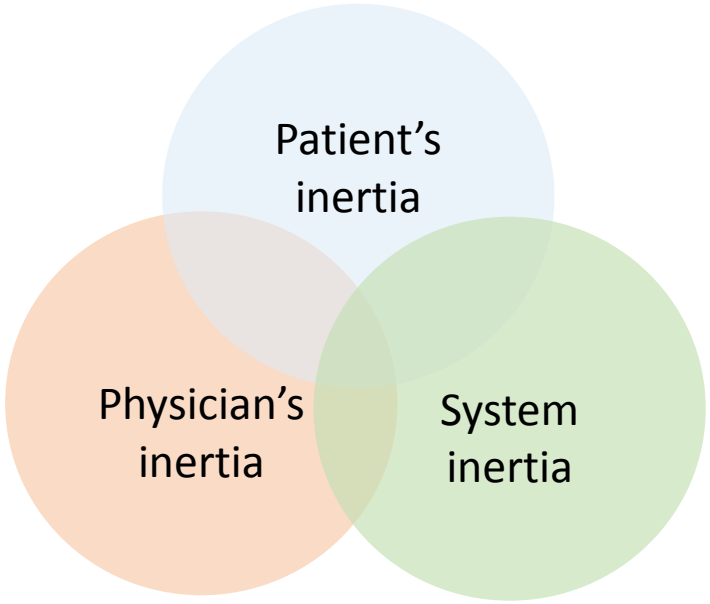
Factors contributing to Clinical Inertia

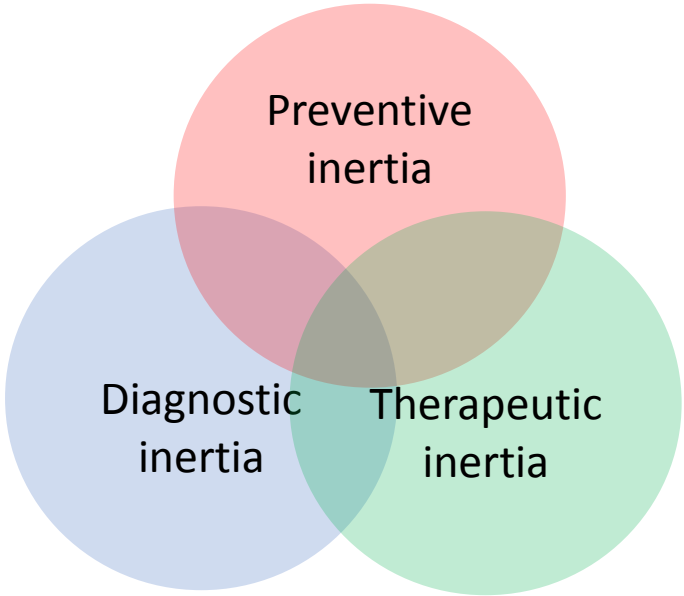
- System-related factors
  - Time concerns
  - Inconsistencies between guidelines
  - Poor planning, communication, and coordination between members of the healthcare team
  - Resource constraints
  - Lack of team approach to care
  - Lack of decision support system

Factors contributing to Clinical Inertia

- Various factors like physician or provider-related, patient-related, and system-related factors are not isolated compartments
  - They are interrelated and overlapping

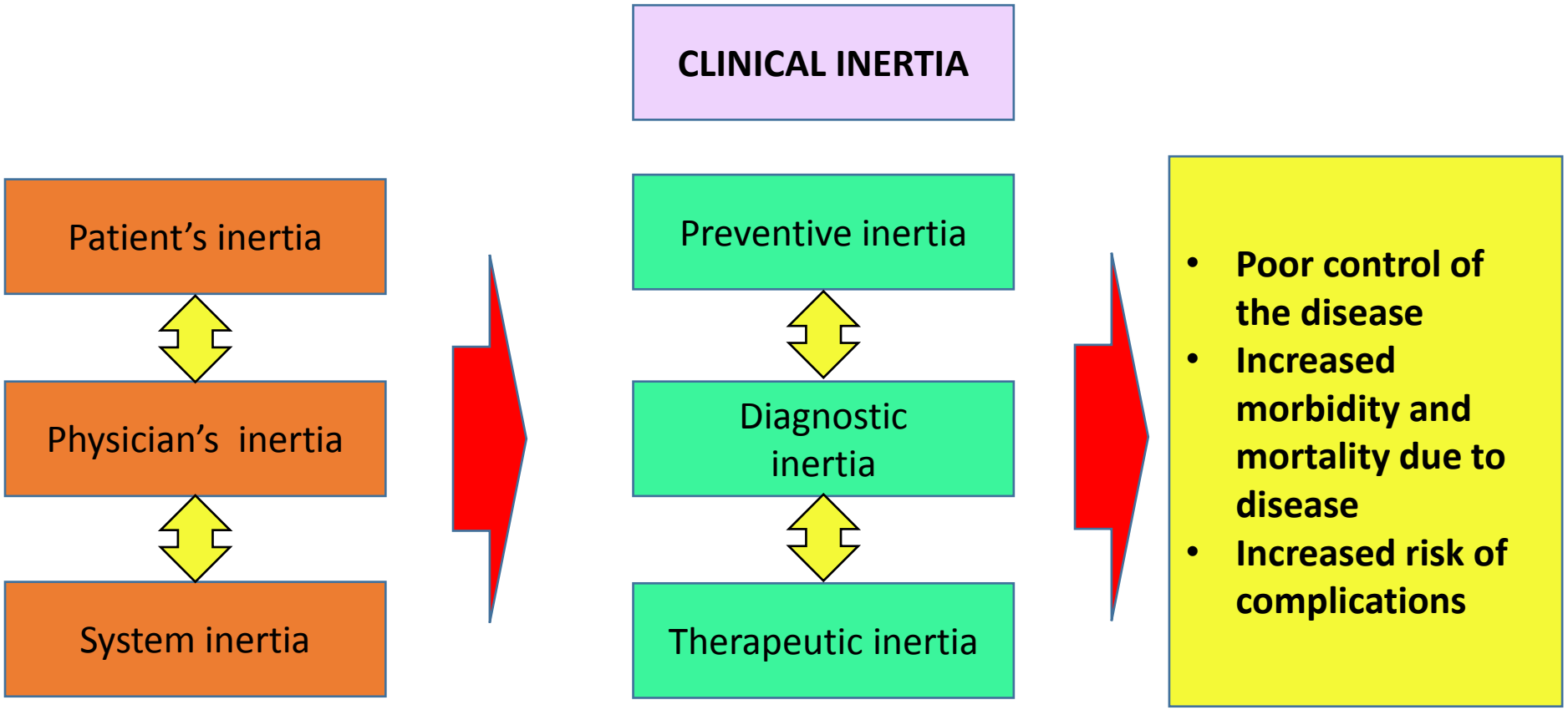

Patient's inertia
Physician's inertia
System inertia
• Stigma associated with sexual health issues
• Difficulty in disclosing sexual health issues
• False belief that there is no treatment for sexual dysfunction
• Embarrassment to discuses about sexual problems
• Lack of knowledge and experience in managing sexual dysfunction
• Time constrains in busy OPD
• Privacy issues in the busy OPD
• Staff shortage and time constrains and privacy
• Lack of proper referral facilities for sexual problems
• Lack of separate department to deal with sexual health issues
• Sexual health issues in the undergraduate medical curriculum


Patient's inertia
Physician's inertia
System inertia


Preventive inertia
Diagnostic inertia
Therapeutic inertia

How to tackle clinical inertia sexual medicine practice

- CI results
  - In improper evaluation and treatment leading to failure to achieve treatment targets
  - Poor control of the disease process
  - Increased risk of disease-associated complications


CLINICAL INERTIA
Patient's inertia
Physician's inertia
System inertia
Preventive inertia
Diagnostic inertia
Therapeutic inertia
• Poor control of the disease
• Increased morbidity and mortality due to disease
• Increased risk of complications

How to tackle clinical inertia sexual medicine practice

- Improving awareness regarding clinical inertia among physicians
- Ongoing medical education and training programs
- Coordination between primary, secondary, and tertiary care
- Adapting current practice guidelines
- Self-evaluation of performance by healthcare professionals
- Use of computer-based decision support system
- Patient education programs
- Improved communication
- Increased direct patient contact time
- Improvement in the system infrastructure
- Multi-disciplinary team approach

How to tackle clinical inertia sexual medicine practice

- A few special factors need to be considered regarding sexual medicine practice.
  - Improving awareness regarding sexual problems in the public
  - Educating the importance of treatment of sexual problems
  - Training regarding the management of sexual health problems to healthcare professionals
  - Ensuring privacy for patients with sexual health issues

Take home message

- CI delays or even denies the best available treatment for the needy patient
- CI exists in all aspects of sexual medicine practice
- Identifying the factors contributing to clinical inertia and tackling it helps to improve patient outcomes

THANK YOU

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