



Poor Physician Adherence to Clinical Guidelines in Hypertension— Time for Physicians to Face Clinical Inertia

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It is now well recognized that individuals with an elevated blood pressure (BP) are at higher risk of developing organ damage (eg, heart failure, myocardial infarction, or stroke or kidney diseases) than individuals with a normal BP. Indeed, there is a logarithmic association of the level of BP with the risk of events, so that even acute life-threatening complications may occur in patients with severe hypertension. Nevertheless, despite some improvements, worldwide surveys have repeatedly shown that high percentages of women and men with hypertension (ranging between 38% and 54%) remain undiagnosed or, when diagnosed, remain either untreated or insufficiently treated (ie, BP is not at target).¹ These surveys revealed substantial variability between low and middle income and high-income countries. Many explanations have been proposed to explain these disappointing figures, including changes in local demography, the aging process, access to care, and the organization of health care systems. In recent years, great attention has been paid to patients' nonadherence to prescribed drugs as an important determinant of uncontrolled BP.^{2,3} Unfortunately, less attention has been paid to the physicians' poor adherence to the implementation of hypertension practice guidelines or therapeutic inertia, which may also have a substantial impact on the rate of hypertension control.

Lu et al⁴ present the results of a content analysis of electronic health records that they performed with the intent to develop a comprehensive taxonomy of scenarios explaining the physicians' suboptimal adherence to guidelines in the ambulatory management of hypertension. To this purpose, they reviewed the data of 100 patients (mean [SD] age at index visit, 66.5 [12.8] years; 50 female [50%]; 8 Black [8%]; 5 Hispanic or Latino [5%]; 85 White [85%]) with a markedly elevated BP in at least 2 consecutive outpatient visits with no new antihypertensive medication prescription within 90 days of the index date.⁴ The mean (SD) systolic and diastolic BPs at the index date were 166.2 (11.5) mm Hg and 87.7 (12.7) mm Hg, respectively.⁴ The median (IQR) time between the 2 visits was 42 (18-85) days.⁴ Comorbidities were frequent in this patient group; of the 100 participants, 23 (23%) had obesity, 16 (16%) had diabetes, and 36 (36%) had cancer.⁴

A variety of scenarios were identified that could have accounted for the noninitiation of an antihypertensive treatment or the nonintensification of an ongoing therapy. Authors⁴ grouped them into 3 main domains: clinician-related scenarios, patient-related scenarios, and clinical complexity-related scenarios. In each of these domains, 2 to 3 explanations were evidenced, such as patient nonadherence or preference for patient scenarios. In the case of clinician-related scenarios, the fact that hypertension was not the reason to consult was a frequent reason not to intervene; in another scenario, clinicians did not consider they were in the position to change anything, and rather considered that the patient's general practitioner should initiate or modify the therapy. Lastly, uncertainties about the diagnosis of hypertension and competing medical priorities were the most common justifications not to intervene because of the complexity of the clinical situation.

The authors of this analysis⁴ provide interesting insights on the various reasons why some clinicians do not initiate or intensify an antihypertensive treatment even though the BP level may be worrying for some patients. In addition to identifying scenarios, they also discussed the barriers that contribute to these scenarios such as unclear institutional role, the distribution of responsibility, high workload, insufficient time, and inadequate infrastructures. In fact, these barriers are well-recognized and reflect, essentially, the situation of many academic institutions or large hospitals, but

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not necessarily that of private practices. Overall, several of these scenarios are legitimate. Thus, it is certainly appropriate not to initiate a treatment when the diagnosis is not confirmed or when a serious competing diagnosis is in the forefront. However, the main issue is not necessarily the absence of antihypertensive drug prescription at the first visit but rather the total absence of any intervention between the first and the second outpatient visit and patients continuing to be untreated or uncontrolled for their elevated BP about 6 weeks later. In fact, this perfectly illustrates the physician clinical inertia, which is probably yet another substantial determinant of the insufficient BP control in the population.⁵ In an important review on clinical inertia published more than 20 years ago, Philips et al⁶ pointed out that "physicians are tempted to lay the blame for clinical inertia at the feet of our patients...(But) there is accumulating evidence to suggest that approximately 75% of the time, physician inertia is the reason for the problem, and approximately 25% of the time, failure to intensify treatment is due to patient refusal or resistance."

Today, one of the important objectives should be to develop strategies to overcome this clinical inertia. Are there effective solutions to reduce medical inertia? As mentioned previously, medical inertia is a complex phenomenon. Hence, one size does not fit all. In a systematic review and meta-analysis of randomized clinical trials to determine which interventions effectively reduce clinical inertia in the pharmacological treatment of hypertension,⁷ addressing clinical inertia through physician reminders, out of office BP monitoring, and educational interventions for primary care clinicians were associated with improved BP control. However, additional approaches have been recommended, such as the use of single pill combinations to simplify drug therapy and achieve a higher percentage of BP control after the first visit or the application of a standardized therapeutic approach according to hypertension guidelines. In this respect, guidelines should be published in a more accessible format and pragmatic recommendations and treatment algorithms should be as simple as possible. In some countries, a regular comparison of the physician's results with those of their peers has been proposed as an effective way to fight against medical inertia.

As mentioned by practicing physicians, the main barrier to improving medical inertia is the time constraint due to patients with complex needs. Indeed, today, in addition to the increased workload, physicians are confronted with an increasing number of patients requiring more time to discuss other comorbidities and risk factors, in addition to adherence issues. This constrain clearly promotes medical inertia but could be overcome by involving all members of the care team (eg, nurses, pharmacists, and dietitians) in the management of hypertension.⁸ Today, team-based care and patient empowerment are strongly recommended as cost-effective ways to improve hypertension management, but collaboration between health care clinicians remains difficult in many countries.

Besides these effective, but sometimes complex, interventions to improve medical inertia, one should not forget that simple moves can also have a strong impact. Thus, as suggested some time ago by O'Connor et al,⁹ "Each office visit represents a precious opportunity to make a clinical move that may benefit a patient. When a patient with uncontrolled hypertension leaves a physician's office without some move being made to control the hypertension, we have missed that opportunity." Therefore, to improve BP control in the population, it is time that physicians face their clinical inertia and start acting whenever BP is untreated or uncontrolled.

ARTICLE INFORMATION

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