Reviewer’s report

Title: Clinical inertia in general practice: a matter of debate. A qualitative study with 114 general practitioners in Belgium

Version: 2 Date: 2 September 2014

Reviewer: Mark Nelson

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Application of clinical guidelines in the real world is somewhat problematic because there are practitioner, patient and system variables at play and as clinicians we only have direct control over the first. However we must be wary of dissonance reduction, explaining away our actions when at odds with the evidence that our patient is likely to benefit from therapeutic intervention or intensification. The statement “appropriate inaction as a result of good clinical reasoning” may encompass this concept. Thus the concept of ‘true CI’ is questionable.

I think therapeutic inertia is a superior term to clinical inertia as the former refers to drug therapy and the latter to drug and lifestyle interventions, e.g. appropriate response to a high BP reading is to question compliance to existing drugs and reinforce the importance of taking the tablets prescribed rather than adding another agent. What we should be dealing with is a high risk compliant patient with uncontrolled blood pressure. They have a clear and unambiguous need for increased drug therapy. Prioritisation in polypharmacy is justified as cardiovascular disease is the common adverse outcome for most common diseases, e.g. diabetes and chronic kidney disease.

Thematic analysis method appropriate.

Specific questions

1. How representative are members of the Société Scientifique de Médecine Générale of the general practitioners in Walloon and Flemish speaking GPs? While sampling is less important in qualitative studies it still should be representative. This needs further explanation for international readers.

2. Table 1. How do these characteristics compare with the Belgian general practice population as a whole?

Minor Essential Revisions

1. “When my patient is a 75 year-old women with a blood pressure as high as 15” do you mean a woman with a BP of 150(mmHg)/15 kPa?

Discretionary Revisions

1. It has already been proposed that the term therapeutic inertia be replaced with
lost therapeutic benefit. I agree that “practitioners need to be helped to overcome CI rather than systematically blamed for inaction”. The latter approach is likely to be counterproductive.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

Have you in the past five years received reimbursements fees funding or salary from an organisation that may in any way gain or lose financially from the publication of this paper either now or in the future? I have served on advisory boards for Schering-Plough Solvay Pharmaceuticals and AMGEN that make products for blood pressure and cholesterol lowering.

Do you have any non-financial competing interests in relation to this paper? I have been the author of a number of national guidelines which of course are irrelevant to Belgium.