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Clinical inertia in medicine: the need for an approach from the human person and Christianity

La inercia clínica en medicina: la necesidad de un enfoque desde la persona humana y el cristianismo

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Abstract

The following text seeks to describe the need for a patient-centered approach to healthcare in settings characterized by limited resources and clinical inertia. The authors argue that, beyond acting ethically and logically in accordance with professional obligations, an approach centered on the individual —with Jesus Christ, the Lord of life, as its central focus— is of paramount importance.

Keywords: spirituality, bioethics, Catholicism, Patient-Centered Care, Decision-Making

1. Introduction

The healthcare system in Peru faces major deficiencies and challenges (1). On the one hand, its fragmentation, insufficient service coverage, the devastation caused by the COVID-19 pandemic, and corruption within the system are factors that impact the quality of care provided to people (2).

In northern Peru, the city of Piura had 1,856,809 inhabitants as of 2017 (5.8% of the national total) (3). On the other hand, Piura was one of the departments with the highest number of COVID-19 cases and mortality rates (4). Furthermore, in a study conducted by the Comptroller General of the Republic of Peru in 2023, it ranks as one of the five most corrupt cities in the country (5). It is within this context that healthcare personnel carry out their duties, and it is in this environment that their work becomes difficult.

In the medical wards of northern Peru, it is common to experience a very strong feeling: the helplessness of being unable to provide adequate care and the necessary support to patients (6). This situation has countless potential explanations (some already outlined above), which we will attempt to analyze. The scarcity and poor distribution of human resources in healthcare —with all the complexity inherent in people— and the lack of diagnostic tests and treatments

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with proven efficacy in hospitals (which, since they are not available at the institution, must be requested privately (7)), may explain this difficult situation.

In this scenario of limited resources, when faced with a patient who is suffering not only from their illness but also from the consequences their hospitalization brings to their family —the anxiety that torments them about returning to their home environment, the need to remain steadfast and not lose heart— it is essential; the factors described are ones that, if we do not take them into account, will result in prolonged hospitalization and make us complicit in an increased risk of higher morbidity and mortality.

On the other hand, faced with a healthcare system plagued by management and administrative shortcomings, and colleagues who are indifferent or just as exhausted as we are(8) —who seem content to simply clock in and process the necessary paperwork (quantity over quality, it should be noted)— we are at greater risk of simply going with the flow and doing the bare minimum ourselves, resigning ourselves to the "it can't be done," "it can't be done," and abandoning all hope of making a difference. It is hard to accept that we have grown accustomed to seeing this as "normal." Ignoring the pain of patients and their families, and hardening our hearts in the face of suffering, IS NOT the answer; we can always do something: Refining our clinical expertise and never overlooking the details is the first step. This approach can make all the difference.

2. Addressing the problem

The term "clinical inertia" has long been used to describe the behavior of healthcare personnel who know they can do something for the patient according to guidelines and recommendations for good clinical practice but fail to do so (9)(10). The reasons may vary:

- Fear of making a decision and making a mistake
- Failure to reconcile one's opinion with that of a colleague who thinks differently,

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- Lack of dialogue with the patient and family members,
- Putting things off until later,
- Letting oneself be overcome by adverse situations (lack of resources),
- Absence of agreed-upon protocols.

Faced with this situation, two attitudes are possible: "going with the flow," that is, simply waiting for things to resolve themselves without acting, or "trying not to give up along the way." Sincere dialogue at the patient's bedside and an approach where the doctor connects with the patient and family as individuals is a necessary alternative. The patient perceives the staff's concern, and this creates an atmosphere of trust that goes beyond the "placebo effect" (11).

There are many occasions when, even with our best efforts, "healing" is beyond our capacity; even alleviating physical discomfort is a war of attrition. But always, ALWAYS, we can offer a kind word, a moment to be present and provide comfort. It is then that it becomes most evident how the noble profession we chose sheds its armor of science and method, and humbly reveals its essence as an art, its sense of love for the human person.

The concepts of intrinsic and extrinsic motivation, widely mentioned and discussed in the literature, only partially address this issue (12). We must go further: passion for what we do, a critical attitude, yet at the same time humility and perseverance; these strengths are necessary for all of us who make up the healthcare team. Offering only diagnostic and therapeutic alternatives with proven clinical efficacy and accessible to the patient, critically evaluating prescriptions and comparing them with the medical history; this approach does not require novel technologies but rather dedication and appreciation for the patient and their situation.

There are numerous moments when healthcare personnel can set aside the *"I"* and focus on the *"You"*; here are a few examples:

1. Treatment and follow-up of pressure ulcers.
2. Debridement and treatment of chronic diabetic foot ulcers; those patients in the Internal Medicine wards waiting for a

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surgical slot (13) due to endless bureaucratic procedures (target hemoglobin of 10 mg/dL, coagulation and bleeding times, and other requests) that have little or no impact on the intra- and postoperative periods.
3. Thorough review of X-rays and CT scans (to the extent our expertise allows), without waiting for the official report.
4. Monitoring of cultures and knowledge of the history of antibiotics received during hospitalization.
5. Verification of compliance with caloric and protein intake for our patients.
6. Verification and maintenance of fluid and electrolyte balance in those who need it.
7. Management of laboratory data and their history, to avoid repeating indiscriminate testing (and sometimes at private or small-scale laboratories) (14).
8. Verification that the family and patient understand the discharge instructions, ensuring whenever possible that this is done well in advance.

An example of this reality is the presentation of clinical cases; the discussion centers on the patient-centered approach (comprehensive medical history, review of the social and epidemiological context, complete physical examination, and syndromic classification), with diagnostic tests taking a secondary role (15). The thoroughness of well-obtained data is not a luxury but a necessity, even more imperative in the clinical contexts of our low- and middle-income countries, where clinical expertise must precede meaningless diagnostic testing.

These actions must be distinguished from "intrusion," in which we perform tasks that do not fall within our purview. The focus of this reality is not the healthcare staff, but the human person and their family; if we believe we are prepared to alleviate suffering and act with good intentions and knowledge, it is legitimate to act as the patient requires. It is essential that all this work be accompanied by teaching through example. We cannot demand that medical interns and residents perform certain actions if we do not teach them how

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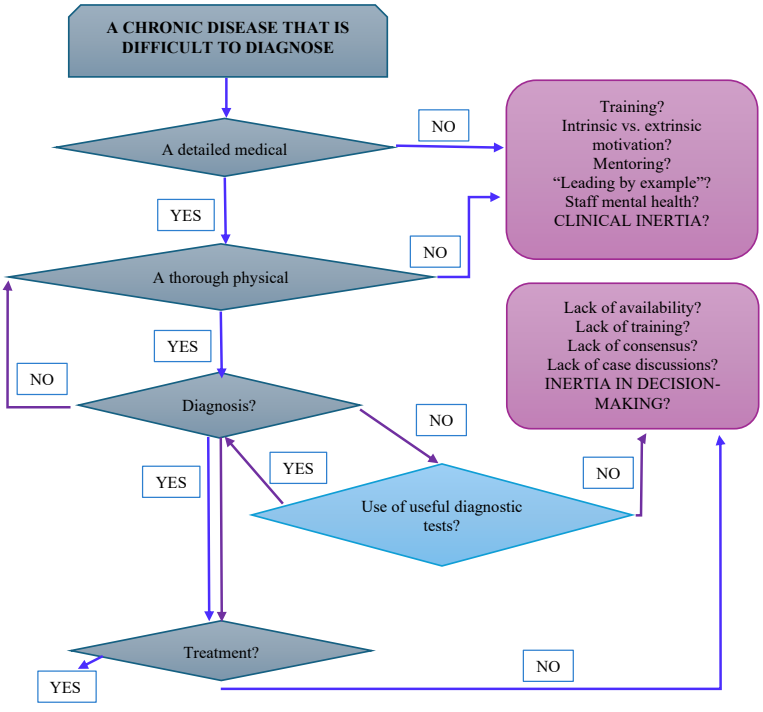
to do so or if we do not emphasize its importance. It is important not to fail in the attempt. The following diagram attempts to illustrate this scenario (with limitations that we must accept from the outset), but it represents an effort, from our perspective, to begin addressing the problem.

Figure 1: A conceptual model of the development of clinical inertia in a resource-limited clinical setting



Source: prepared by authors.

3. A Perspective from bioethics

Medical practice is a profession that requires ethical analysis in decision-making, which has two fundamental dimensions: one scientific

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and the other human; in both, the commitment of healthcare personnel—who care for others in their time of suffering—is essential; this is the dignity of the health sciences professions, grounded in the responsibility to protect the health and well-being of others; to ensure quality medical care, it is essential that medical professionals adhere to a set of ethical and moral principles (16).

Therefore, ethics and bioethics provide healthcare professionals with evaluative and interpretive resources that help them discern the most appropriate practices and the factual elements that foster a humanized approach, as part of a pro-life culture, especially if we consider the personalist current of bioethics as a philosophical foundation, which promotes above all, respect, defense, and promotion of life; the body is not merely an instrument to be repaired, but rather forms part of one's very essence, as the sole and necessary foundation for existence in time and space. Every healthcare act and intervention on the body is the action of one person upon another, because one of them is the subject of the healthcare intervention. In this way, respect for the body is the principle upon which other values are built, such as freedom, sociability, and one's own future project (17).

Within this framework of respect for the ontological dignity of the person, there must be a profound reflection by all stakeholders to assess the capacity of medical services to provide safe, timely, efficient, and person-centered medical care, respecting the patient's dignity and autonomy and in accordance with their expectations. Undoubtedly, adopting this person-centered perspective, especially given the deep-rooted dehumanization of modern medical practice, will serve as an excellent countermeasure against clinical inertia, as the ongoing process of humanistic reflection within medical practice will enable continuous professional improvement of services and processes.

Within the complex genesis of clinical inertia, bioethics also compels us to consider the training environments of future professionals, whether in the family, university, or workplace settings:

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- In the first, as the initial laboratory for engaging with others, learning to work in teams, and knowing how to listen.
- In the second, where one begins to encounter real situations of suffering, inequality, and inequity, especially in clinical medicine courses, where future professionals can interact with people and realize that what books and articles say can only partially apply to realities like ours. More is needed.
- Finally, in hospitals and other settings, trainees, by interacting with peers and role models, can learn from others: expertise, perseverance, active listening, a passion for reading, and many other attitudes and behaviors in which the patient is not valued and is not the center of care.
- Therefore, it is important to lead by example in caring for, accompanying, and comforting patients (18).

3.1. Can we go further?

Medical inertia, which at first glance we might simply describe as a lack of professionalism, commitment, or even humanity, may in many cases have a deeper origin. It must have one. The physician routinely faces a mysterious human phenomenon: *suffering*, often profound, and often endured by the innocent. Many of the patients whom we doctors have helped, we have met on the worst day of their lives (19). Anyone who pauses before this tremendous scene of the pain and suffering of a fellow human, will not pass by without first being transformed, for better or for worse. After each encounter, they will have moved toward virtue or corruption, but they will not remain indifferent.

And how much is one willing to do for this fellow human standing before them, marked by suffering? A very important preliminary question is *who does one believe is standing before them?* If one believes they are facing a necessary evil that must be dealt with in order to make ends meet, they will treat the patient with all the contempt

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permitted by institutional regulations and the patient's defenselessness. If one merely believes they are facing another human being —but one who is finite, insignificant, and doomed sooner or later to death— they may perhaps offer only the minimum required by medical protocols and what is essential to avoid future medical-legal complications.

However, for healthcare personnel who center their actions on God, their vision of the suffering person takes on a deeper meaning. Specifically, for Catholic healthcare personnel, the sufferer is the image of the Lord Jesus Christ, and they are called to believe that they are touching the flesh of that same Lord who has chosen to continue living and suffering in that person, and for that reason, they must love him. Whatever they do will seem insufficient, and their effort will know no bounds or limits. This is why the encounter with suffering not only reveals the intention and soul of healthcare workers but also transforms them.

The Gospel beautifully shows us the paradigm of the helper, offered by Jesus, in the parable of the Good Samaritan (20). The Lord presents us with an archetype of someone who goes far beyond his duty, who accompanies others beyond what human solidarity demands. He is moved by love. These two men (the one attacked by robbers and the Samaritan) have undoubtedly been transformed in this encounter. One, receiving from the other the helping hand of the Lord. The other, assisting the Lord in his brother. But those who passed by (the priest and the Levite) have also been undeniably transformed. They have necessarily had to inflict a crippling wound on their own souls to silence them. Inertia, in our view, is much more than indifference; it is the progressive tearing apart of one's own conscience.

Christian healthcare workers, therefore, must take the Lord as their model when providing care to their patients. One thought, however, that may be unsettling is that all those sick people healed or even raised from the dead by the Lord eventually died; perhaps afflicted by a different illness than the one from which they were delivered.

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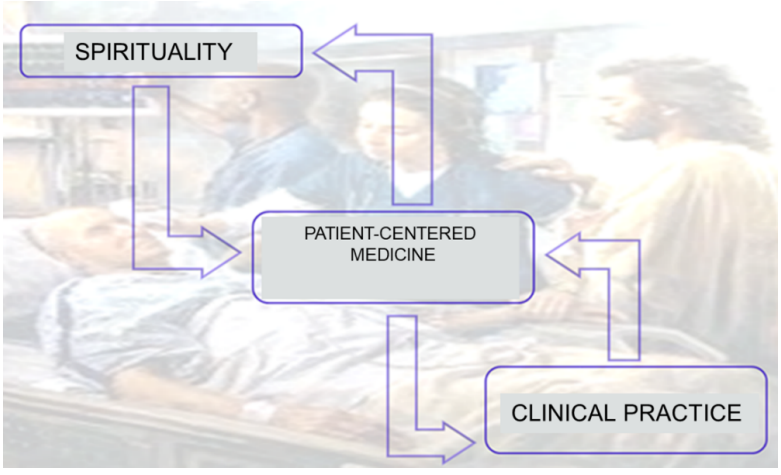
One might ask: Why does the Lord of Life grant someone a temporary good like health, which will eventually be lost? This is a fundamental question for those of us who also seek to provide healing. We believe the answer is this: The Lord grants a temporary good in order to grant, through it, a definitive good Himself.

Therefore, for us who, imitating the Master, also seek to offer health, it would make no sense to do so if, following that temporary good, we do not offer the definitive good, which is the Lord. Broadening the perspective slightly, no good —whether material or immaterial— makes sense to be given if, following it, the supreme good, which is the Lord, is not offered.

We have attempted to illustrate this concept in Figure 2.

Figure 2: Illustration of the proposed approach to addressing clinical inertia



Source: prepared by authors.

4. Conclusion

Despite limitations in human and administrative resources and time, healthcare personnel must be prepared—not only in terms of theo-

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retical and practical knowledge and in upholding ethical standards in their profession—but also in knowing how to support and care for their patients as individuals. Ultimately, however, we firmly believe that they can go even further: dedicating themselves to others by following the example of the Lord of Life.

Authors' Contributions

Chang-Dávila Domingo, Manrique Márquez María Virginia, Ñique-Carbajal Cesar, and León Jiménez Franco Ernesto: participated in the literature review, writing the first draft, revising and editing it, and writing and approving the final version.

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Conflicts of Interest

The authors declare that they have no conflicts of interest.

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