eAppendix

Characteristics of the selected documents

Document type and accessibility
Of the documents selected, 43 (60.6%) were original articles and 22 (31.0%) were review articles. The rest of the documents were notes, book chapters, conference papers, and editorials. The number of documents by their type are shown in the web exclusive appendix (eAppendix Figure 2). Of the documents selected, 47 (66.2%) were accessible by subscription and 24 (33.8%) were open access.

Publications by year
The selected documents were published between 2001 and 2020. Of all documents identified, 17 (23.9%) were published before 2010 and 54 (76.1%) were published after 2010. Figure 1 shows year of publication of documents reporting on factors associated with therapeutic/clinical inertia in caring for patients with hypertension that were included in this study.

Country of origin
For the documents selected, 41 (57.7%) corresponding authors were based in the United States, 7 (9.9%) were based in Spain, and 6 (8.5%) were based in Canada. Corresponding authors of the other documents were based in France, United Kingdom, Australia, Netherlands, Sweden, Italy, China, Ghana, Mexico, Sri Lanka, Brazil, and Germany. Countries from where the study originated are shown in the web exclusive appendix (eAppendix Figure 3).

Source of funding
Of the documents, the majority (70.4%) had not received or did not declare receiving funding. However, 17 (23.9%) received funding from health institutions or pharmaceutical/medical companies. Sources of funding of the documents selected in this study are shown in the web exclusive appendix (eAppendix Figure 4).

Journals in which more than one document were published
In this study, there were 11 journals in which more than one document was published. The journals in which more than one document were published are listed with their CiteScore, SNIP, SJR, and IF in the eAppendix Table. A total of 13 (18.3%) documents were published in Journal of Clinical Hypertension. Three documents were published in each of the following journals: Journal of General Internal Medicine, Current Hypertension Reports, and Journal of the American Society of Hypertension.

Factors associated with the physician
The documents included in this study reported that therapeutic/clinical inertia could occur as a consequence to lack of in-depth understanding of the clinical pathology underlying the disease among some physicians. It is noteworthy mentioning that adequate understanding of the pathophysiology that underly a disease is a prerequisite to effectively manage that disease. Therapeutic/clinical inertia could also be associated with failure of the physicians to initiate treatment, set achievable goals, titrate doses, and address comorbidities that could be associated with hypertension.

In clinical practice, physicians should promptly and adequately set achievable goals, design a therapeutic plan, initiate therapy, monitor therapy to achieve the pre-determined therapeutic goals, and manage other comorbidities that could be associated with the disease. Therapeutic/clinical inertia could also be associated with imbalanced dialogue/communication between the physician and patient during the clinical encounter. When one of the parties hijack the encounter, likelihood of therapeutic/clinical inertia apparently increases. Additionally, physicians should allocate enough time to address the patient health concerns during the clinical encounters. Apparently, therapeutic/clinical inertia might be more prevalent in shorter clinical encounters. To minimize therapeutic/clinical inertia, physicians are encouraged to adopt a proactive care approach rather than a reactive one. Physicians should not wait until the complications of hypertension appear, rather, they should address them and minimize the chances of their occurrence.

Healthcare systems are far from being perfect and there is always a room for improvement. Probably, therapeutic/clinical inertia could be minimized with improvements in healthcare delivery and the healthcare services provided. Physicians should not underestimate the number of patients who need intensification of the pharmacotherapy and should not use “soft
excuses” to avoid intensification of the pharmacotherapy. Physicians should also keep in mind that some therapeutic option might fail and it is not always due to lack of patient adherence. Therefore, physicians should monitor and evaluate their patients periodically and intensify/modify their therapeutic plans accordingly.

In modern healthcare delivery, patients are increasingly involved in their healthcare. It is common that patients and physicians take joint decisions. Physicians should keep in mind that patients might resist intensification of pharmacotherapy. As a result, physicians may need to spend extra time explaining to the patients why intensification of the pharmacotherapy might be necessary. In many cases, physicians are not adequately trained on supporting active care, using tools to support active care, and/or have office system that supports active care. These factors were also reported to be associated with therapeutic/clinical inertia.

Physicians should not underestimate the importance of addressing risk factors and the benefits of pharmacotherapy for patients with hypertension. Although pharmacotherapy could be associated with side effects, the risks of the side effects should not be overestimated. Physicians should also keep up with and adhere to the current consensus-based guidelines in managing hypertension.

Factors associated with the patient
The documents included in this study showed that therapeutic/clinical inertia could be associated with patient denying hypertension, underestimating the consequences of hypertension on their health, and showing resistance to adopting lifestyles that are compatible with hypertension. These factors could be prevalent among patients with low health literacy. Decision makers in healthcare authorities should design adequate interventions to increase health literacy among patients with hypertension.

Therapeutic/clinical inertia could also be associated with lack of affordability of the pharmacotherapy. Decision makers in health authorities should address the prices and affordability of the pharmacotherapy. In many cases, polypharmacy in managing hypertension was prevalent and many of the medications used were associated with significant side effects. Adherence to current consensus-based guidelines and screening for presence of side effects might allow addressing them and hence might reduce therapeutic/clinical inertia. Patients having emotional states and abusing substance could also be associated with therapeutic/clinical inertia.
Improving communication and trust between the patients and their caring physicians could reduce therapeutic/clinical inertia.

**Factors associated with the healthcare system**
The documents included in this study reported that therapeutic/clinical inertia was associated with lack of availability/access to current consensus-based clinical guidelines, lack of decision support systems, lack of active overreach systems, lack of national registries, lack of visit planning systems, and lack of multi-healthcare provider team approach to healthcare. Decision makers in the healthcare systems should consider increasing availability/access and adherence to current consensus-based clinical guidelines. Decision makers in healthcare systems should also consider implementing decision support systems, active overreach systems, national registries, visit planning systems, and multi-healthcare provider teams. Such implementation might reduce therapeutic/clinical inertia.
### eAppendix Table. Journals in which more than one document were published

<table>
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<tr>
<th>#</th>
<th>Journal</th>
<th>CiteScore¹</th>
<th>SNIP¹</th>
<th>SJR¹</th>
<th>Publisher</th>
<th>Number of documents</th>
<th>%</th>
<th>IF²</th>
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<tr>
<td>1</td>
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1CiteScore, SNIP, and SJR were obtained from Scopus sources through https://www.scopus.com/sources

2IF was obtained from the Journal Citation Reports (JCR) 2019 of Clarivate Analytics
**eAppendix Figure 1.** Flow diagram of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA)

Documents identified through the database search \((n = 4,622)\)

- # of records after duplicates removed \((n = 3,128)\)
  - # of records excluded \((n = 1,494)\)
  - # of records excluded \((n = 1,703)\)
- # of records screened
  - # of records excluded \((n = 1,191)\)
- # of full-text articles assessed for eligibility \((n = 234)\)
  - # of records excluded \((n = 163)\)
- # of studies included in qualitative synthesis \((n = 71)\)
eAppendix Figure 2. Co-citation Map of Documents Reporting on Therapeutic Inertia in Caring for Patients With Hypertension
eAppendix Figure 3. Co-occurrence Map of All 112 Keywords Grouped Into 4 Clusters
eAppendix Figure 4. Number of documents distributed by their type

![Bar chart showing the number of documents distributed by type.](chart.png)
**eAppendix Figure 5.** Number of documents distributed by the country in which the corresponding author was based in
eAppendix Figure 6. Sources of funding of the documents selected in this study

![Bar chart showing the number of documents funded by different bodies. The chart indicates a majority of documents were not funded or not declared.](chart_image)