

Promoters of Therapeutic Inertia in Managing Hypertension: A Consensus-Based Study

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In clinical practice, hypertension is one of the most commonly encountered and managed health conditions.^{1,2} According to some estimates, there are more than 1.38 billion individuals with hypertension around the world.³ In Palestine, hypertension is very common in adults, with an estimated prevalence rate of around 27.6%.⁴

Recent studies have identified initiating, modifying, and intensifying pharmacotherapy of hypertension as gaps that need to be bridged in evidence-based practice.⁵⁻⁸ Although guidelines for evidence-based management of hypertension are available, devising individualized pharmacotherapeutic plans for patients can be hindered by humanistic factors related to the health care provider, the patient receiving pharmacotherapy, or the infrastructure of the health care system.⁹⁻¹⁸ As a result, many patients fail to attain their therapeutic goals. Although many factors could be contributing to this failure, therapeutic inertia has been highlighted as one of the most significant contributors.^{19,20}

Therapeutic inertia, clinical inertia, or physician inertia is a phenomenon in which clinicians fail to manage at least 1 patient condition as a result of lack of adequate intervention.¹⁹ Therapeutic inertia has been recognized in the management of certain chronic conditions for which algorithms and pharmacotherapeutic objectives have been well established, including hypertension, dyslipidemia, diabetes, arthritis, osteoporosis, and gout.^{7,19,21-25}

Findings of previous studies have shown that therapeutic inertia in hypertension was highly prevalent in various health care systems.²⁶ The burden of therapeutic inertia in certain health conditions could be severe. It has been estimated that therapeutic inertia could be responsible for the vast majority (up to 80%) of cardiovascular accidents.^{27,28} Optimal control of blood pressure reduced mortality rates from coronary heart disease and cerebrovascular disease by 20% and 24%, respectively.²⁶ Therefore, therapeutic inertia should be eliminated to achieve optimal control of blood pressure and other pharmacotherapeutic goals in patients with hypertension.^{29,30}

Pharmacotherapy is within the purview of clinicians. The literature does not narrate intensively the promoters of therapeutic inertia from the point of view of clinicians involved in providing health

ABSTRACT

OBJECTIVES: Hypertension is among the most commonly managed diseases in general practice. Therapeutic inertia could be responsible for the vast majority of cardiovascular events in patients with hypertension. The present study was conducted to explore views and opinions of clinicians involved in providing health care services to patients with hypertension in Palestine and achieve formal consensus on promoters of the phenomenon of therapeutic inertia from their point of view.

STUDY DESIGN: In this exploratory study, a mixed-methods approach combining literature search, qualitative interviews, and 2 Delphi technique rounds was used.

METHODS: Interviews with key contact clinicians (n = 18) were conducted. To achieve formal consensus on promoters of therapeutic inertia in hypertension, 2 Delphi rounds were conducted using a panel of general practitioners, family medicine specialists, and internal medicine specialists (n = 50).

RESULTS: The majority of the panel members (90%) agreed that therapeutic inertia was prevalent in treating patients with hypertension in Palestine. Of the 41 potential promoters, consensus was achieved on 37 (90.2%). Of these 37 promoters, 21 (56.8%) were clinician-related, 10 (27.0%) were patient-related, and 6 (16.2%) were health care system-related factors. The study explored views and opinions of clinicians involved in providing health care services to patients with hypertension in Palestine relevant to therapeutic inertia in hypertension.

CONCLUSIONS: Findings of this study could inform policy and decision makers to devise strategies to eliminate or reduce therapeutic inertia in managing hypertension in Palestinian clinical practice. Future studies are needed to determine whether such strategies can improve outcomes of patients with hypertension.

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care services to patients with hypertension. To reduce therapeutic inertia in hypertension and improve control of blood pressure, understanding what promotes therapeutic inertia in managing hypertension could be of great importance. Identifying and understanding promoters of therapeutic inertia in hypertension might be essential for devising effective interventions to address therapeutic inertia and improve patient outcomes.^{16,18}

Previous studies have identified some potential promoters of therapeutic inertia.^{18,31,32} However, little is known about whether these promoters would be formally accepted by clinicians involved in providing health care services to patients with hypertension in Palestine. Therefore, this exploratory study was conducted to explore views and opinions of such clinicians with regard to therapeutic inertia and to achieve formal consensus on promoters of the phenomenon in managing hypertension in Palestinian clinical practice from their point of view. Such consensus-based promoters might be targeted with future interventional strategies to eliminate or reduce the phenomenon and improve outcomes of patients with hypertension in Palestine.

METHODS

Study Design

In this exploratory study, a mixed-methods approach combining literature search, interviews with experts, and a 2-round Delphi technique was used.^{18,33-44} This study is reported in adherence to the Consolidated criteria for REporting Qualitative research (COREQ) checklist.⁴⁵ Adherence to the COREQ checklist is shown in [eAppendix A](#) (eAppendices available at [ajmc.com](#)).

Collection of Potential Promoters of Therapeutic Inertia

An extensive literature search was performed to collect promoters of therapeutic inertia in hypertension that were published in previous research. Results of the literature search were reported separately.

The interviews with clinicians were conducted privately in their places of work to explore their views and opinions on therapeutic inertia and what factors promoted the phenomenon in Palestinian clinical practice from their point of view.¹⁸ Key contacts—clinicians who were general practitioners in primary care (n = 5), family medicine specialists (n = 6), and internal medicine specialists (n = 7)—were contacted and interviewed on their views on therapeutic inertia in hypertension and factors that promoted the phenomenon in the Palestinian context. During the interviews, clinicians were asked open-ended questions to extract their views and opinions on the prevalence of therapeutic inertia and the factors they thought promoted therapeutic inertia in managing hypertension in Palestine. Factors identified through the literature and those mentioned by the clinicians during the interviews were compiled into a list.

TAKEAWAY POINTS

We identified consensus-based promoters of clinical inertia in managing hypertension. Policy makers should address these promoters to improve health-related outcomes in hypertension.

- ▶ Therapeutic inertia can be responsible for the majority of cardiovascular events.
- ▶ Promoters of clinical inertia may vary among health care systems.
- ▶ Consensus was achieved on 37 promoters of clinical inertia in managing hypertension.

The Delphi Technique

Formal consensus among the panel of clinicians on promoters of therapeutic inertia in managing patients with hypertension in Palestinian clinical practice was sought using the Delphi technique.⁴⁶⁻⁴⁸

The Panel

A panel of clinicians who were involved in providing health care services to patients with hypertension in Palestinian clinical practice was formed. A judgmental sampling technique was utilized to identify, approach, invite, consent, and recruit the clinicians to the panel. Candidate clinicians were identified through key contacts in clinical practice. The design and aims of this exploratory study were explained to the candidate panelists by the field researchers. The following inclusion criteria were used to identify and recruit candidate clinicians to the panel: (1) having a formal license to practice medicine in Palestine, (2) being affiliated with a main health care facility providing health care services for patients with hypertension, (3) caring for at least 5 patients with hypertension per week, and (4) having experience of at least 5 years in providing health care services for patients with hypertension in Palestine. All panelists were clinicians who provided health care services for patients with hypertension in Palestine. We purposefully recruited only clinicians who were legally permitted to prescribe antihypertensive pharmacotherapy for patients with hypertension. The clinicians were invited from 10 different sites.

The Study Tool

The study tool used was a paper-based questionnaire that contained 3 separate parts. The first part collected the sociodemographic and practice variables of the panelists, including age, gender, number of years in clinical practice, and specialty. The second part contained questions to which clinicians had to respond with either disagree (no), neutral, or agree (yes). These questions were on (1) prevalence of therapeutic inertia in managing patients with hypertension in Palestinian clinical practice; (2) whether more efforts were needed to eliminate the phenomenon of the therapeutic inertia in managing hypertension in Palestinian clinical practice; (3) whether the clinician was ever invited to attend a training, workshop, symposium, or lecture on therapeutic inertia; (4) whether guidelines or recommendations to reduce or eliminate therapeutic inertia in managing hypertension in Palestinian clinical practice existed; and (5) whether such guidelines or recommendations were needed to reduce therapeutic inertia in managing hypertension in Palestinian

TABLE 1. Clinicians Who Took Part in the Study (n=50): Sociodemographic and Practice Details

Characteristic	n	%
Gender		
Male	32	64.0
Female	18	36.0
Age in years		
< 40	34	68.0
≥ 40	16	32.0
Specialty		
General practitioner	27	54.0
Internal medicine	13	26.0
Family medicine	10	20.0
Number of years in practice		
< 10	23	46.0
≥ 10	27	54.0

clinical practice. Part 3 contained the list of potential promoters collected from the search and those identified during the interviews with the key clinicians. The study tool is provided in [eAppendix B](#). The study tool was piloted for clarity, comprehensibility, and readability by 5 clinicians.

The Iterative Delphi Rounds

Formal consensus was sought on promoters of therapeutic inertia in managing hypertension in Palestinian clinical practice using 2 iterative rounds of the Delphi technique among a panel of clinicians involved in providing health care services to patients with hypertension in Palestinian clinical practice.

The First Round

The clinicians responded to the study tool by providing their sociodemographic and practice variables in the first section. The clinicians also responded to the questions relevant to therapeutic inertia in the second part by either disagree (no), neutral, or agree (yes). In part 3, the clinicians rated each listed factor using a Likert scale of 1 to 9. After each factor, a space was provided for qualitative comments meant to justify or qualify the rating provided by the clinicians.

Analysis of the Ratings

Definitions of consensus were informed by those used in previous studies.^{18,33-44} Ratings of the panelists on each factor were incorporated into an Excel spreadsheet (Microsoft Inc). The descriptive statistics—first quartile, median, third quartile, and the interquartile range (IQR)—were calculated using Excel's statistical and computational functions. In this study, the definitions of consensus were as follows: (1) consensus to exclude the factor from the final list of promoters of therapeutic inertia in managing hypertension in Palestinian clinical practice, when the median of the ratings fell

within the range of 1 to 3 and the IQR was less than or equal to 2; (2) consensus to include the factor in the final list, when the median of the ratings fell within the range of 7 to 9 and the IQR was less than or equal to 2; and (3) equivocal, when the median of the ratings fell within the range of 4 to 6 and/or the IQR was more than 2. We decided a priori to consider all equivocal factors in a second round.

The Second Round

All equivocal factors in the first round were considered in the second round. In this round, the considered factors were included in a revised study tool and given to the clinician for reconsideration. For each equivocal factor, the clinicians were provided with the following information: (1) a reminder of the clinician's own rating in the first round, (2) the median of the ratings and IQR of all clinicians, and (3) summary of comments provided by the clinicians to justify or qualify their rating. The clinicians were asked if they wanted to reconsider their opinions after reviewing the information provided on each listed factor. This step has been used to limit the number of rounds needed to achieve consensus.^{42,44,49}

The same definitions of consensus used in the first round were again used in the second round. A third round was not needed to achieve consensus on equivocal factors because clinicians made obvious comments allowing a conclusion that consensus would not be possible in a third round.

Ethics Approval

This explorative consensus-based study received ethical approval from the Institutional Review Board Committee of An-Najah National University. All clinicians provided informed consent.

RESULTS

In the first Delphi round, responses were obtained from all 50 clinicians (100%) invited. In the second Delphi round, responses were obtained from 45 clinicians (90%).

Characteristics of the Clinician Panelists

The panel included male and female clinicians. Twenty-three (46%) were internal medicine and family medicine specialists and 27 (54%) had practice experience of 10 or more years in providing health care services to patients with hypertension. The detailed sociodemographic and practice details of the clinicians who took part in the study are shown in [Table 1](#).

Opinions on Therapeutic Inertia

The majority of the clinicians (90%) agreed that therapeutic inertia was prevalent in managing hypertension in Palestinian clinical practice and 90% also agreed on the need to exert more efforts to eliminate or reduce it. None of the clinicians (0%) reported being invited to attend a training, workshop, symposium, or lecture on therapeutic inertia. All clinicians (100%) stated that they have not heard of any guidelines or recommendations to eliminate or reduce

therapeutic inertia in managing hypertension, and they also all (100%) agreed that these guidelines or recommendations were required to eliminate or reduce this phenomenon in Palestinian clinical practice.

Factors the Panelists Believed Promoted the Existence of Therapeutic Inertia in Managing Hypertension

Of the 41 potential promoters on the initial list, consensus was achieved on 37 (90.2%) promoters of the phenomenon. The details of the promoters are presented in [Table 2](#). Of the 37 promoters on which formal consensus was achieved, 21 (56.8%) were clinician-related, 10 (27.0%) were patient-related, and 6 (16.2%) were health care system-related factors.

Factors on Which Consensus Was Not Achieved Among the Panel

Consensus was not achieved on 4 (9.8%) potential promoters of therapeutic inertia. These factors (details shown in [Table 3](#)) remained equivocal at the end of the second round.

DISCUSSION

This exploratory study sought to expose views and opinions of clinicians involved in providing health care services to patients with hypertension in Palestine with regard to therapeutic inertia. The study also sought to achieve consensus on promoters of therapeutic inertia in managing hypertension from the clinicians' point of view. To our best knowledge, this exploratory consensus-based study is the first study among clinicians who are involved in providing health care services to patients with hypertension in Palestine. Findings of the present study could be informative to clinicians, health regulatory authorities, researchers, academicians, and all stakeholders interested in combating the phenomenon of therapeutic inertia. It has been argued that therapeutic inertia can be eliminated or reduced by appropriately designed interventions.^{18,50}

The clinician panelists were recruited using a judgmental sampling technique. Historically, nonprobability and nonrandomized sampling techniques have been associated with bias.⁵¹ However, the design and objectives of this study limited the use of randomized probability sampling techniques.^{18,35,36} To achieve consensus on a concept using a formal consensus technique, it is a prerequisite for a panelist to have prior knowledge of the concept on which consensus is being sought. The sampling technique used in this study permitted recruiting clinicians who were actively involved in providing clinical health care services to patients in Palestine with hypertension based on the inclusion criteria. In Palestine, patients with hypertension receive health care services from general practitioners, family medicine specialists, and internal medicine specialists. Therefore, the clinicians invited and recruited were from these specialties. The size of the panel of clinicians was consistent with those used in previous explorative and consensus-based studies in which views and opinions of stakeholders were sought and consensus was developed on concepts in health care.^{18,33-44}

Not surprisingly, the clinicians who took part in this study were of the opinion that therapeutic inertia was prevalent in managing hypertension in Palestinian clinical practice. The study's findings were consistent with those reported on managing hypertension in previous studies conducted elsewhere.⁵²⁻⁵⁵ The clinicians wanted to see more efforts to eliminate or reduce therapeutic inertia in managing hypertension in Palestinian clinical practice. Views of the clinicians on the existence of therapeutic inertia in managing hypertension in Palestine were also consistent with those reported on managing dyslipidemia in Palestine.¹⁸ The phenomenon of therapeutic inertia was also shown to be highly prevalent in other health conditions including diabetes and dyslipidemia^{16,17,56-58}; in fact, it has been reported that therapeutic inertia may be part of up to 50% of patient-clinician encounters among patients with diabetes.¹⁶ Not surprisingly, none of the clinicians had ever been invited to attend any training, conference, meeting, or lecture on therapeutic inertia. Similarly, no guidelines or recommendations to eliminate or reduce therapeutic inertia were noted to exist. Findings of this study were consistent with those reported by clinicians caring for patients with dyslipidemia in Palestine.¹⁸ Our findings highlight the existence of this gap and the need to develop guidelines and recommendations and organize training.^{16,31}

Findings of this study complement those reported on therapeutic inertia in hypertension and other health conditions.^{16-18,31,52,53} In this study, more than half (56.8%) of the promoters were clinician-related factors, and clinicians have previously been recognized as contributors to the phenomenon of clinical inertia.^{16,56-58} Lack of time, initiation, intensification, dose titration, and addressing comorbidities were cited as promoters of therapeutic inertia. Additionally, allowing patients to dominate the encounter, blaming the patient, adopting reactive strategies, lacking support of active care, overrating the quality of health care services provided, and lacking adherence to guidelines promoted therapeutic inertia. Understanding clinician-related factors might help decision makers in health care authorities and professional groups support clinicians in providing optimal health care services to patients with hypertension.⁵² The clinicians were of the opinion that denial, underestimating the risks of hypertension, resistance to lifestyle modifications, lack of health literacy, lack of financial resources, polypharmacy, fear of adverse effects, poor communication, and lack of trust were patient-related factors that promoted therapeutic inertia in managing hypertension. Consensus was also achieved on promoters related to the health care system, including the lack of each of the following: current guidelines, decision support system, active outreach system, disease registry for hypertension, visit planning system, and team approach in managing patients with hypertension. Our findings were consistent with those reported in previous studies.^{18,19,31,59,60}

Limitations

This exploratory consensus-based study has a number of limitations. First, all participants who took part were clinicians who were general practitioners, family medicine specialists, or internal

TABLE 2. Promoters of Therapeutic Inertia in Managing Hypertension in Palestinian Clinical Practice on Which Consensus Was Achieved

No.	Promoters: "Therapeutic inertia in managing hypertension in Palestinian clinical practice is promoted by...:"	Round in which consensus was achieved
Promoters related to clinicians		
1	Failure of clinicians to initiate antihypertensive pharmacotherapy	2
2	Failure of clinicians to titrate doses of antihypertensive medications to achieve pharmacotherapeutic goals	2
3	Failure of clinicians to recognize and manage comorbidities occurring along with hypertension	2
4	Patients dominating the clinical encounter with clinician	1
5	Clinicians lacking enough time to address/manage all health issues of patients with hypertension	2
6	Clinicians adopting a reactive instead of a proactive strategy in managing hypertension and its comorbidities	2
7	Clinicians overrating the quality of health care services already provided to patients with hypertension	2
8	Clinicians underestimating the proportion of patients with hypertension who need their pharmacotherapy to be intensified	1
9	Clinicians making soft excuses to avoid intensification of pharmacotherapy when it is needed	1
10	Clinicians blaming patients with hypertension for lack of adherence to the recommendations provided in previous encounters	2
11	Clinicians deciding that patients with hypertension would resist suggestions to intensifying pharmacotherapy without even asking the patients	1
12	Clinicians lacking relevant knowledge needed to support/promote active care of patients with hypertension	1
13	Clinicians lacking relevant tools needed to support/promote active care of patients with hypertension	1
14	Clinicians lacking relevant training needed to support/promote active care of patients with hypertension	1
15	Clinicians lacking relevant office systems needed to support/promote active care of patients with hypertension	1
16	Clinicians underestimating and/or not addressing risk factors of hypertension	2
17	Clinicians underestimating benefits of pharmacotherapy for patients with hypertension	1
18	Clinicians overestimating risks of adverse effects of pharmacotherapy for patients with hypertension	1
19	Clinicians lacking awareness of the current guidelines used in managing hypertension	1
20	Clinicians disagreeing with the current guidelines used in the management of hypertension	1
21	Clinicians disagreeing with the applicability of the current guidelines used in the management of hypertension	1
Promoters related to patients		
1	Patients denying having hypertension	1
2	Patients believing that hypertension is not a health condition that is serious enough to warrant pharmacotherapy	1
3	Patients resisting adoption of a lifestyle compatible with hypertension	1
4	Patients continuing to have low health literacy related to hypertension and associated comorbidities	1
5	Patients lacking exposure to or not receiving educational/awareness programs, campaigns, or advertisements	2
6	Patients who cannot afford the costs associated with pharmacotherapy	1
7	Patients who need to take more than 1 medication for managing hypertension	2
8	Patients experiencing adverse effects associated with pharmacotherapy for hypertension	2
9	Patients communicating poorly with their clinicians	2
10	Patients lacking trust in their clinicians and their recommendations	2
Promoters related to the health care system		
<i>Absence of each of the following:</i>		
1	Current clinical guidelines used for managing hypertension	1
2	Decision support system	1
3	Active outreach system	1
4	Disease registry for hypertension	1
5	Visit planning system	2
6	Team approach in managing hypertension	1

TABLE 3. Factors That Remained Equivocal After the Second Round

No.	Factor
1	Therapeutic inertia in managing hypertension in Palestinian clinical practice is promoted by clinicians failing to understand the pathogenesis of hypertension
2	Therapeutic inertia in managing hypertension in Palestinian clinical practice is promoted by clinicians failing to set clinical goals for their patients with hypertension
3	Therapeutic inertia in managing hypertension in Palestinian clinical practice is promoted by patients abusing substances
4	Therapeutic inertia in managing hypertension in Palestinian clinical practice is promoted by patients experiencing negative emotional states

medicine specialists. Although this was done intentionally, inclusion of other health care professionals such as cardiologists, endocrinologists, pharmacists, nurses, and dieticians could have allowed the collection of their views on provision of health care services for patients with hypertension.⁶¹ Second, the panel size was relatively small (although the high response rate obtained could be considered a strength). Third, patients were not included in the panel. Inclusion of patients would have provided further insights into the phenomenon from their perspectives. Fourth, decision makers from health authorities were not included. Finally, this study was qualitative in nature. Qualitative studies are limited by their approach compared with randomized controlled trials. A “gold standard” in identifying promoters of therapeutic inertia in managing hypertension is not existent. In its absence and in the absence of empirical evidence, formal consensus methods like the Delphi technique might provide alternative means to address the phenomenon of therapeutic inertia.

CONCLUSIONS

The study explored views and opinions of clinicians involved in providing health care services to patients with hypertension in Palestine that are relevant to therapeutic inertia in hypertension. From the point of view of the clinicians, the promoters of therapeutic inertia in hypertension were clinician-related, patient-related, and health care system-related factors. Findings of this study could inform policy and decision makers to devise strategies to eliminate or reduce therapeutic inertia in managing hypertension in Palestinian clinical practice. Future studies are needed to determine if such strategies can improve outcomes of patients with hypertension. ■

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eAppendix A. Adherence to COnsolidated criteria for REporting Qualitative research (COREQ)

Checklist [1]

#	Topic	Guide Questions/Description	Page/Line # in the manuscript
	Domain 1: Research team and reflexivity		
	<i>Personal characteristics</i>		
1	Interviewer/facilitator	Which author/s conducted the interview or focus group?	Page 5 Line 15-16
2	Credentials	What were the researcher's credentials? E.g. PhD, MD	Page 5 Line 15-16
3	Occupation	What was their occupation at the time of the study?	Page 5 Line 15-16
4	Gender	Was the researcher male or female?	Page 5 Line 15-16
5	Experience and training	What experience or training did the researcher have?	Page 5 Line 15-18
	<i>Relationship with participants</i>		
6	Relationship established	Was a relationship established prior to study commencement?	Page 5 Line 13-15
7	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Page 5 Line 13-15
8	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Page 5 Line 18-19
	Domain 2: Study design		
	<i>Theoretical framework</i>		
9	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Page 5 Line 22-23
	<i>Participant selection</i>		
10	Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Page 5 Line 30-32

11	Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Page 5 Line 32-33
12	Sample size	How many participants were in the study?	Page 8 Lines 6-10 and Table 1
13	Non-participation	How many people refused to participate or dropped out? Reasons?	NA
	<i>Setting</i>		
14	Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Page 5 Lines 10-11
15	Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 5 Lines 10-11
16	Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Page 8 Lines 6-10 and Table 1
	<i>Data collection</i>		
17	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Page 5 Lines 10-23
18	Repeat interviews	Were repeat interviews carried out? If yes, how many?	Page 5 Lines 22-23
19	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 5 Lines 22-23
20	Field notes	Were field notes made during and/or after the interview or focus group?	Page 5 Lines 22-23
21	Duration	What was the duration of the interviews or focus group?	Page 5 Lines 25-26
22	Data saturation	Was data saturation discussed?	Page 5 Lines 24-25
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Page 5 Lines 24-25
	Domain 3: analysis and findings		
	<i>Data analysis</i>		
24	Number of data coders	How many data coders coded the data?	Page 5 Lines 23
25	Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26	Derivation of themes	Were themes identified in advance or derived from the data?	Page 5 Lines 23-25

27	Software	What software, if applicable, was used to manage the data?	N/A
28	Participant checking	Did participants provide feedback on the findings?	Page 5 Lines 24-25
	<i>Reporting</i>		
29	Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Table 2 and 3
30	Data and findings consistent	Was there consistency between the data presented and the findings?	N/A
31	Clarity of major themes	Were major themes clearly presented in the findings?	Tables 2 and 3
32	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Tables 2 and 3

Reference:

1. Tong A, Sainsbury P, Craig J: **Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups.** *International journal for quality in health care : journal of the International Society for Quality in Health Care* 2007, **19(6):349-357.**

eAppendix B.

The study tool

Promoters of therapeutic inertia in managing hypertension

“Therapeutic inertia” is a recently described phenomenon of physicians failing to intensify medication regimens at encounters with patients who have uncontrolled risk factors. In this study, we are investigating the factors that promote therapeutic inertia in managing hypertension in the Palestinian practice.

Part I: Please fill in your sociodemographic and practice details:

1. Gender: Male Female
2. Age (years):
3. Qualifications (academic degrees, board certificates):
.....
4. When did you graduate with the first degree?
5. Specialty:
6. Number of years in practice?
7. Place of work?

Part II: Please respond to the following items:

1. Do you think therapeutic inertia is prevalent in managing hypertensive patients in the Palestinian clinical practice? Yes No I am not sure
2. Do you think more efforts are needed to eliminate the phenomenon of therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice? Yes No I am not sure
3. Have you been invited or have you had any training (workshop, symposium, conference, lecture, etc) on therapeutic inertia? Yes No, if yes, when?
4. Are you aware of any clinical guidelines to eliminate or reduce therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice? Yes No I am not sure
5. Do you think these guidelines are needed to reduce therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice? Yes No I am not sure

Part III: Factors promoting therapeutic inertia in managing patients with hypertension

In your opinion what factors contribute to therapeutic inertia (failing to intensify medication regimens at encounters with patients who have uncontrolled blood pressure) in hypertension? Please indicate the degree to which you disagree or agree with the below listed factors on a scale of 1 (complete disagreement) to 9 (complete agreement).

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
1	Physician Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians failing to	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
	understand the pathogenesis of hypertension									
	Comment (optional)									
2	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by failure of the clinician to initiate antihypertensive pharmacotherapy	1	2	3	4	5	6	7	8	9
	Comment (optional)									
3	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by failure of the clinician to titrate doses of antihypertensive medications to achieve the pharmacotherapeutic goals	1	2	3	4	5	6	7	8	9
	Comment (optional)									
4	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians failing to set clinical goals for their hypertensive patients	1	2	3	4	5	6	7	8	9
	Comment (optional)									
5	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by failure of the clinician to recognize and manage the comorbidities occurring along with hypertension	1	2	3	4	5	6	7	8	9
	Comment (optional)									
6	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients dominating the clinical encounter with the clinician	1	2	3	4	5	6	7	8	9
	Comment (optional)									
7	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
	<p>enough time to address/manage all health issues of hypertensive patients</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice could be promoted when the clinician adopts a reactive instead of a proactive strategy in the management of hypertension and its comorbidities</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians overrating the quality of healthcare services already provided to hypertensive patients</p>	1	2	3	4	5	6	7	8	9
8										
9										
10	<p>promoted by clinicians underestimating the proportion of hypertensive patients that need their pharmacotherapy to be intensified</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians making soft excuses to avoid intensification of the pharmacotherapy when it is needed</p>	1	2	3	4	5	6	7	8	9
11										
12	<p>promoted by clinicians blaming hypertensive patients for lack of adherence to the recommendations provided in the previous encounters</p>	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
13	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice could be promoted by clinicians deciding that hypertensive patients would resist suggestions to intensifying pharmacotherapy without even asking the patients</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinician lacking relevant knowledge needed to support/promote active care of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
14	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking relevant tools needed to support/promote active care of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
15	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking relevant training needed to support/promote active care of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
16	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking relevant office system needed to support/promote active care of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
17	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking relevant office system needed to support/promote active care of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
18	<p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the</p>	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
19	<p>Palestinian clinical practice is promoted by clinicians underestimating and/or not addressing risk factors of hypertension</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians underestimating the benefits of pharmacotherapy for hypertensive patients</p>	1	2	3	4	5	6	7	8	9
20	<p>Palestinian clinical practice is promoted by clinicians overestimating the risks of side effects of pharmacotherapy for hypertensive patients</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians overestimating the risks of side effects of pharmacotherapy for hypertensive patients</p>	1	2	3	4	5	6	7	8	9
21	<p>Palestinian clinical practice is promoted by clinicians lacking awareness of the current guidelines used in managing hypertensive patients</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians lacking awareness of the current guidelines used in managing hypertensive patients</p>	1	2	3	4	5	6	7	8	9
22	<p>Palestinian clinical practice is promoted by clinicians disagreeing with the current guidelines used in the management of hypertensive patients</p> <p>Comment (optional) Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by clinicians disagreeing with the current guidelines used in the management of hypertensive patients</p>	1	2	3	4	5	6	7	8	9
23	<p>Palestinian clinical practice is promoted by clinicians disagreeing with the applicability of the current</p>	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
6	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients who cannot afford the costs associated with pharmacotherapy Comment (optional)	1	2	3	4	5	6	7	8	9
7	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients who need to take more than one medication for the management of their hypertension Comment (optional)	1	2	3	4	5	6	7	8	9
8	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients experiencing side effects associated with the pharmacotherapy of hypertension Comment (optional)	1	2	3	4	5	6	7	8	9
9	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients abusing substance Comment (optional)	1	2	3	4	5	6	7	8	9
10	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients having emotional states Comment (optional)	1	2	3	4	5	6	7	8	9
11	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by patients communicating poorly with their clinicians Comment (optional)	1	2	3	4	5	6	7	8	9
12	Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is	1	2	3	4	5	6	7	8	9

#	Promoters	Level of disagreement			Indecisive			Level of agreement		
1	<p>promoted by patients lacking trust in their clinicians and their recommendations</p> <p>Comment (optional)</p> <p>Healthcare system</p> <p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of current clinical guidelines used for managing hypertensive patients</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9
2	<p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of decision support system</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9
3	<p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of active outreach system</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9
4	<p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of disease registry for hypertension</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9
5	<p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of visit planning system</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9
6	<p>Therapeutic inertia in managing hypertensive patients in the Palestinian clinical practice is promoted by absence of team-approach in managing hypertensive patients</p> <p>Comment (optional)</p>	1	2	3	4	5	6	7	8	9

Would you like to add more promoters that were not included?

Thank you very much