Table 2. Reported Health Behaviors by Medical Conspiracism

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Respondents Who Regularly Engage in the Behavior, % (N = 1351)</th>
<th>No. of Medical Conspiracy Theories Agreed With</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take herbal supplements</td>
<td>Total: 20</td>
<td>0: 13, 1 or 2: 22, ≥3: 35</td>
</tr>
<tr>
<td></td>
<td>Buy local/farm stand food</td>
<td>23: 14, 30</td>
</tr>
<tr>
<td>Prioritize organic food consumption</td>
<td>21: 18, 22, 24</td>
<td></td>
</tr>
<tr>
<td>Take vitamins</td>
<td>57: 54, 61, 58</td>
<td></td>
</tr>
<tr>
<td>Get annual physical examination</td>
<td>45: 48, 46, 37</td>
<td></td>
</tr>
<tr>
<td>Get influenza shot</td>
<td>35: 39, 36, 25</td>
<td></td>
</tr>
<tr>
<td>Visit dentist</td>
<td>41: 44, 39, 33</td>
<td></td>
</tr>
<tr>
<td>Use sunscreen</td>
<td>35: 38, 34, 30</td>
<td></td>
</tr>
</tbody>
</table>

recognize that most individuals who endorse these narratives are otherwise “normal” and that conspiracism arises from common attribution processes. Medical conspiracism may also be a diagnostic tool for health practitioners because conspiracists are less willing to follow traditional medical advice, such as using sunscreens or vaccines, and are more likely to use alternative treatments.

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Study concept and design: Both authors.
Acquisition of data: Oliver.
Analysis and interpretation of data: Both authors.
Drafting of the manuscript: Oliver.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Both authors.
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Results | The mean (SD) age of patients was 64.5 (8.8) years; 74.1% were women, 79.1% were Hispanic, 44.9% were diagnosed as having depression, and 61.2% had DM. On average, participants had a prior visit SBP of 158.7 (15.7) mm Hg, current visit SBP of 154.6 (16.7) mm Hg, were taking 2.5 (1.1) BP medications, and had 5.3 (2.3) problems addressed during the visit. Clinical inertia was more common among depressed than nondepressed patients (70% vs 51%; P = .02). Depression diagnosis was associated with clinical inertia in both the adjusted and unadjusted multilevel analyses (relative risk [RR], 1.40; 95% CI, 1.11-1.74; P = .004; adjusted relative risk [ARR], 1.49; 95% CI, 1.06-2.10; P = .02). The relationship remained after excluding those with at least 1 documented home or clinical
SBP measurement below goal (ARR, 1.74; 95% CI, 1.07-2.83; \( P = .03 \)), adjusting for adherence counseling (ARR, 1.49; 95% CI, 1.10-2.04; \( P = .01 \)) and excluding patients with DM with SBP 140 mm Hg or lower (ARR, 1.49; 95% CI, 0.99-2.23; \( P = .06 \)).

Discussion | Among patients with uncontrolled hypertension, clinical inertia was more likely in those with a diagnosis of depression. Hence, clinical inertia may be 1 mechanism by which depressed patients have worse cardiovascular outcomes. Research has shown that patients with mental illness receive less intensive medical care, such as coronary revascularization; our study extends this literature by demonstrating differences in clinician behavior with respect to cardiovascular risk factor management in this population. Future studies should explore the underlying processes that affect clinician treatment practices when managing a patient with depression. In the meantime, PCPs should be cautious about undertreating cardiovascular risk factors among patients identified as having depression.

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Author Contributions: Dr Moise had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Moise, Davidson, Kronish. Acquisition of data: Moise, Shea, Kronish. Analysis and interpretation of data: Moise, Chaplin, Shea, Kronish. Drafting of the manuscript: Moise. Critical revision of the manuscript for important intellectual content: All authors. Statistical analysis: Moise, Chaplin, Shea, Kronish. Obtained funding: Davidson, Kronish. Administrative, technical, and material support: Kronish. Study supervision: Davidson, Shea, Kronish.

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Editor’s Note

Multimorbidity, Guidelines, and Clinical Inertia

Many guidelines and performance measures for chronic conditions, such as hypertension, seem to assume that patients come neatly packaged with only 1 problem. But patients’ conditions are often more complicated, and many patients have more than 1 condition. We know little about the impact that this multimorbidity has on care for common conditions like hypertension.

The Research Letter by Moise et al is novel because it clearly demonstrates that co-occurrence of depression has a significant impact on the treatment of hypertension. Specifically, patients who had a blood pressure higher than 140/90 mm Hg were less likely to have their hypertension medications intensified if they also had depression. Moise et al refer to this as clinical inertia. But is clinical inertia always bad? The answer is not clear.

In some cases, clinicians may have thought that their patients’ depression was more pressing than their hypertension. Especially if the blood pressure elevation was modest, over the long-term, management of the hypertension may be best optimized by first managing depression. When a patient has multiple problems, it is challenging to prioritize what needs to be done “this visit” and what is best managed over a longer time horizon. The study by Moise et al demonstrates that we need to think hard about the best management strategies for patients with multiple medical problems.

Kenneth E. Covinsky, MD

HEALTH CARE REFORM

Headaches and Neuroimaging: High Utilization and Costs Despite Guidelines

While most headaches are attributable to benign conditions, patients and physicians are often concerned about intracranial pathologic conditions. However, the yield of significant abnormalities on neuroimaging in patients with chronic headaches is 1% to 3%.1-3 Given the comparable yield in patients without headaches, multiple guidelines have recommended against routine headache neuroimaging,4-6 and ef-