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Talking with patients is better than talking to patients

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Patients manage chronic illnesses, clinicians don't. Each day patients decide which medications to administer, which activities to participate in, and which foods to eat. In making these decisions they try to arrive at a somewhat rational balancing of hopes for their futures and demands of their presents. They must decide what to do with the understanding that their knowledge of the illness is imperfect, and is smaller than that of the person who wrote the prescriptions and made the recommendations. And so their decisions must inevitably include a judgment about the clinician. How much can I rely on what he or she told me? Does what he told me help me with my hopes? Does what she told me fit my present?

There is a growing body of literature that teaches clinicians how to communicate with patients in a way that helps patients make those inevitable judgments and achieve better health outcomes. The paper by Schoenthaler and colleagues¹ in this issue of *Circulation: Cardiovascular Quality and Outcomes* adds to that literature. Although its lessons apply to all patients, it also suggests persuasively that better communication might help mitigate African American health disparities.

The authors audiotaped clinic visits between 92 hypertensive patients and 27 primary care providers. The patients as a group were socioeconomically disadvantaged as judged by educational attainment, income, and health insurance data. Fifty seven percent of the patients were African American. The investigators used a standardized quantitative analysis method to characterize provider-patient communication, computed scores for 6 characteristics of that communication, then related those scores to subsequent 3-month medication adherence measured by electronic pill cap monitoring. Fifty eight percent of patients were labeled as having "poor adherence", defined as belonging in one of three statistically-generated clusters determined by mean adherence and adherence variability. They found that less focus on psychosocial circumstances (e.g. living situation, relationship with partner), fewer information exchanges about antihypertensive medications, and fewer partnership-building exchanges, were independent predictors of poor adherence. They found

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a significant interaction between psychosocial focus and race, with a stronger relationship between low psychosocial focus and poor adherence among African American patients.

There is good support in the literature for the concept that how we communicate with patients affects their subsequent medication adherence. A meta-analysis published in 2009² identified 106 studies that reported a correlation between good communication and better subsequent adherence. In 21 studies of the effect of communication skills training, they found a 12% higher risk of poor adherence when physicians had not received a training intervention.

There is also good support in the literature for the concept that the quality of patient-provider communication is influenced by patient race.³ African American patients report lower trust in healthcare providers.⁴ Cooper and colleagues⁵ studied the communication of 18 African American and 13 white physicians with their African American or white patients. When visits were race-concordant, visits were longer, had slower speech speed, and were rated as more positive and participatory. Patient-centered communication did not explain differences in patients' perceptions of interaction by race concordance, suggesting the relationship was mediated by other factors.

Bias, prejudice, and stereotyping may be among these other factors. We have found a relationship between providers' levels of implicit racial bias and African American patients' ratings of relationships with their providers.⁶ For the patient, subtle experiences of bias can result in stereotype threat. Stereotype threat occurs when cues in the environment (such as visiting a doctor's office) trigger the threat of confirming, as self-characteristic, a negative stereotype about one's group.⁷ A patient feeling stereotype threat can experience increased anxiety and reduced memory, which may impair the patient's communication and ability to absorb information during a doctor's visit.⁷ Based on this poor clinical interaction, the patient may feel less activated to adhere to treatment recommendations. We have used a technique that is hypothesized to reduce stereotype known as values affirmation to improve race discordant patient-provider communication⁸; the impact of reducing stereotype threat on subsequent adherence remains to be demonstrated.

The study has limitations. It appears to rely on a definition of poor adherence that, while statistically elegant, has limited clinical interpretability. The authors defined 5 clusters of adherence types with 2 corresponding to high adherence and 3 corresponding to "poor" adherence. However, one of the poor adherence clusters had an average adherence of 86.4%, which falls well above the threshold of 80% used to define poor adherence in most prior studies. Although this adaptive modeling approach allows variability of adherence over time to be considered, ultimately grouping patients with adherence ranges of 88–115% and 5–63% into a similar "poor adherence" group may reduce any advantages of the approach. The high expense of electronic medication caps frequently limits the number of medications investigators can monitor. In this study providers were asked to decide on a single medication to monitor, and they may have made biased decisions. While calcium channel blockers were the most frequently prescribed medications ACE inhibitors were the most frequently monitored, and ACE inhibitor monitoring was a risk factor for poor adherence. "Patient-centeredness" is a difficult concept to measure⁹; in the current study patient-

centeredness was considered greater when the ratio of relationship-building to biomedical exchanges was greater.

In our judgment, however, these limitations do not invalidate the results. Measuring the complex concepts of adherence and patient-centeredness is difficult, and the authors have made reasoned judgments about methodology.

Regarding recommendations for next steps in research and practice, we believe that the evidence base for linking communication and adherence is strong enough that the focus should begin to be on implementation. The paper by Schoenthaler et al suggests that simple recommendations, such as exploring patients' psychosocial situations, may improve adherence and diminish racial disparities. It will be important to understand the barriers to implementing simple recommendations such as this one, and to devise means to work past the barriers. Better communication will help those who manage chronic illness – our patients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

References

1. Schoenthaler A, Knafl GJ, Fiscella K, Ogedegbe G. Addressing the social needs of hypertensive patients: The role of patient-provider communication as a predictor of medication adherence. *Circ Cardiovasc Qual Outcomes*. 2017; 10:e003659. [PubMed: 28830861]
2. Haskard Zolnieriek KB, Dimatteo MR. Physician communication and patient adherence to treatment: A meta-analysis. *Med Care*. 2009; 47:826–834. [PubMed: 19584762]
3. Hagiwara N, Penner LA, Gonzalez R, Eggly S, Dovidio JF, Gaertner SL, West T, Albrecht TL. Racial attitudes, physician-patient talk time ratio, and adherence in racially discordant medical interactions. *Soc Sci Med*. 2013; 87:123–131. [PubMed: 23631787]
4. Hughes Halbert C, Armstrong K, Gandy OH, Shaker L. Racial differences in trust in health care providers. *Arch Int Med*. 2006; 166:896–901. [PubMed: 16636216]
5. Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med*. 2003; 139:9079–15.
6. Blair IV, Steiner JF, Fairclough D, Hanratty R, Price DW, Katz HE, Wright LA, Bronsert M, Karimkhani E, Magid DJ, Havranek EP. Clinicians' implicit ethnic/racial bias predicts patients' perceptions of care among black but not Latino patients. *Ann Fam Med*. 2013; 11:43–52. [PubMed: 23319505]
7. Burgess DJ, Warren J, Phelan S, Dovidio J, van Ryn M. Stereotype threat and health disparities: What medical educators and future physicians need to know. *J Gen Intern Med*. 2010; 25(Suppl 2):S169–177. [PubMed: 20352514]
8. Havranek EP, Hanratty R, Tate C, Dickinson LM, Steiner JF, Cohen G, Blair IA. The effect of values-affirmation on race-discordant patient-provider communication. *Arch Int Med*. 2012; 172:1662–1667. [PubMed: 23128568]
9. Epstein RM, Franks P, Fiscella K, Shields CG, Meldrum SC, Kravitz RL, Duberstein PR. Measuring patient-centered communication in patient-physician consultations: Theoretical and practical issues. *Soc Sci Med*. 2005; 61:1516–1528. [PubMed: 16005784]