FROM THE EDITORS' DESK

From the Editors' Desk: Why Does Not Improvement in Communication Lead to Improvement in "Hard" Outcomes?

Jeffrey L. Jackson, MD, MPH

Zablocki VAMC, Milwaukee, WI, USA.

J Gen Intern Med 34(6):779–80
DOI: 10.1007/s11606-018-4819-6
© Society of General Internal Medicine (This is a U.S. government work and not under copyright protection in the U.S.; foreign copyright protection may apply) 2019

The quality of communication is important in provider-patient interactions. Studies have consistently shown that encounters that are more interactive result in patients with higher levels of satisfaction and trust.[1] What has been more difficult to achieve is translating improvement in communication to other outcomes, such as improved hypertension or diabetes control. Most studies of communication interventions that have looked for effects beyond improvement in satisfaction have found no benefit.[1–3] This is surprising since improvement in communication can lead to improved adherence to treatment regimens[4–6] and adherence has been shown to be critical to improvement in some outcomes, such as blood pressure control.[7]

I once attended a "Meet the Professor" session at the annual Society of General Internal Medicine with Shelly Greenfield. The room was full of young researchers, all eager to push the field of patient-provider communication forward and looking forward to his guidance. He was the author of one of the few studies that showed that improving patient-provider communication led to better diabetic control and quality of life.[8] We were shocked when he told us that he had moved out of the field of patient-provider communication because of frustration over the lack of impact from communication interventions on outcomes other than trust and satisfaction, an issue because funding agencies were interested in improving "hard" outcomes. He told us that while communication interventions could and did improve the quality of communication, and that some outcomes, such as trust and satisfaction, were sensitive to patient-provider communication, by and large other outcomes, such as blood pressure and diabetes control were not. His guidance was to get out of the field! Many of us were already engaged in trials to improve communication with the goal of improving additional outcomes and left the room disheartened, but determined to prove him wrong.

We are still trying. It is not surprising that Vo and colleagues found that a pre-clinic email message asking patients with poorly controlled diabetics to submit their top 1–2 priorities for the visit resulted in greater patient satisfaction and improved patient-reported communication quality, but no improvement in diabetic control.[9]

Most studies that have tested interventions to improve communication have reported on the impact on the provider-patient interaction (either directly with audiotapes or indirectly with patient reports) as well as satisfaction or trust, but have not looked at other outcomes. Why is this so?

There are clues that emerge from this body of work. First, it is critical that interventions involve both the provider and the patient. When the intervention focuses on just one of the two participants in the encounters, it invariably fails.[1] Secondly, improving outcomes is complicated. While the belief that improving communication improves adherence and thus improvement in adherent sensitive outcomes is appealing, it is too simplistic. The milieu that leads to patients having good blood pressure or diabetic control is multifactorial. Adherence, for example, can be affected by communication, but there are many factors, often unique to individual patients, that result in the degree of adherence they experience.[7] It is clear from these communication interventions that the impact of communication on adherence may be less than the impact of other factors. If the patient cannot afford to buy their medications, if the patient's health beliefs or social support system is working against improvement in blood pressure or diabetes control, then improving communication will lead to failure. Third, the key factor in translating improvement in communication to improved outcomes may prove to be patient activation. Patient activation is the knowledge, skills, and confidence a person has in managing their own health and health care. Patients that are more activated and engaged in self-care have better outcomes, including better blood pressure control.[10] Providers with more positive beliefs about the patient's role in self-management have more activated patients. Activated patients engage in a range of behaviors that can lead to improved outcomes. It is possible that interventions that improve patient satisfaction and trust did not lead to more activated patients. The key to improving other outcomes may be in developing interventions that activate patients. It is likely that activating patients will require a stronger, more multi-disciplinary approach.

One has to ask, is it really necessary to look for improvement in communication outcomes beyond resulting in more satisfied and trusting patients? It may be a legacy of our biomedical models that we continue to seek improvement in "real" or "important" outcomes, rather than just accepting that

Published online January 25, 2019

better communication leads to improvement in satisfaction and trust but not in other "hard" outcomes. Satisfaction and trust are themselves important outcomes. Future work might look at how well physicians and patients feel that interventions actually address the patient's priorities. In times of exorbitant costs and worsening social determinants for lower SES patients, improving trust and communication alone is likely not enough to fix the system.

Corresponding Author: *Jeffrey L. Jackson, MD, MPH; Zablocki VAMC, Milwaukee, WI, USA (e-mail: jjackson@mcw.edu).*

Compliance with Ethical Standards:

Conflict of Interest: *The author declares that he does not have a conflict of interest.*

Publisher's Note: *Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*

REFERENCES

1. **Jackson JL**. A Randomized Trial to Improve Communication between Patients and Providers in a Primary Care Walk-in Clinic. J Gen Intern Med. 2018. 33(4):404–405.
2. **Frosch DL**, **Rincon D**, **Ochoa S**, **Mangione CM**. Activating seniors to improve chronic disease care: results from a pilot intervention study. J Am Geriatr Soc 2010; 58(8):1496–1503.
3. **Griffin SJ**, **Kinmonth AL**, **Veltman MW**, **Gillard S**, **Grant J**, **Stewart M**. Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: a systematic review of trials. Ann Fam Med 2004; 2(6):595–608.
4. **Roter DL**, **Hall JA**. Communication and adherence: moving from prediction to understanding. Med Care 2009; 47(8):823–825.
5. **Schneider J**, **Kaplan SH**, **Greenfield S**, **Li W**, **Wilson IB**. Better physician-patient relationships are associated with higher reported adherence to antiretroviral therapy in patients with HIV infection. J Gen Intern Med 2004; 19(11):1096–1103.
6. **Lee SQ**, **Raamkumar AS**, **Li J**, **Cao Y**, **Witedwittayanusat K**, **Chen L**, **Theng YL**. Reasons for Primary Medication Nonadherence: A Systematic Review and Metric Analysis. J Manag Care Spec Pharm. 2018;24(8):778–794.
7. **Kronish IM**, **Moise N**, **McGinn T**, **Quan Y**, **Chaplin W**, **Gallagher BD**, **Davidson KW**. An Electronic Adherence Measurement Intervention to Reduce Clinical Inertia in the Treatment of Uncontrolled Hypertension: The MATCH Cluster Randomized Clinical Trial. J Gen Intern Med. 2016;31(11):1294–1300.
8. **Greenfield S**, **Kaplan SH**, **Ware JE Jr**, **Yano EM**, **Frank HJ**. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. J Gen Intern Med 1988; 3(5):448–457.
9. **Vo MT**, **Uratsu CS**, **Estacio KR**, **Altschuler A**, **Kim E**, **Alexeeff SE**, **Adams AS**, **Schmittdiel JA**, **Heisler M**, **Grant RW**. Prompting Patients with Poorly Controlled Diabetes to Identify Visit Priorities Before Primary Care Visits: A Pragmatic Cluster Randomized Trial. J Gen Intern Med. https://doi.org/10.1007/s11606-018-4756-4
10. **Greene J**, **Hibbard JH**. Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. J Gen Intern Med 2012; 27(5):520–526.