

# Communicating for optimal cardiovascular prevention: understanding the clinician's role

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**Submitted:** 28 April 2026; **Accepted:** 30 April 2026

**Online publication:** 30 April 2026

Arch Med Sci 2026; 22 (2): 652–654

DOI: <https://doi.org/10.5114/aoms/221406>

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Reflecting on his career as the Director of the National Institutes of Health (NIH) in the United States (US), Dr. Francis Collins noted that, “maybe we underinvested in research on human behavior” [1]. This was an acknowledgement of the complexities involved in the delivery of health care, and specifically in the role that trust and communication have in the adoption of recommended medical care. Prior research has shown that trust is increased when patients feel that a physician has listened, shared adequate details, provided anticipatory guidance, and engaged in shared decision making [2]. As the environments and the ways in which we practice continue to change over time, largely driven by culture, technology, and clinical demands, we must continuously reevaluate the impact of these changes on patient communication and quality of medical care. Surveys of US adults show that trust in physicians and hospitals decreased from 71.5% to 40.1% from 2020 to 2024, reaffirming the need for research into physician-patient communication strategies that can begin to rebuild trust in health care [3]. Effective communication enhances the patient experience and increases willingness to accept recommended care.

There is ample evidence of this connection in cardiovascular disease (CVD) prevention. CVD remains a leading cause of morbidity and mortality worldwide and delayed or inadequate management of cardiometabolic risk factors contributes to the high burden of disease [4]. Medication nonadherence increases cardiovascular risk and is anticipated to become more significant over the upcoming years given the aging population living with multiple medical comorbidities [5]. Improving adherence to medication regimens requires an understanding of the factors driving individual health behaviors. This may include a patient's perceived lack of medication effectiveness, concern over possible side effects, affordability of the medication, poor communication between the clinician and the patient, societal and cultural norms, and distrust of the health care system among additional reasons. Understanding the unique concerns and circumstances of the individual patient requires effective communication and will allow a personalized approach to patient care, as opposed to generic advice to “take the medication as prescribed”.

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) are a prime example of this. There are multiple considerations when trying to understand the high discontinuation rates for GLP-1 RAs in the US when used for obesity management. These include affordability, gastrointes-

tinal side effects, lack of response to the medication, patient preference, misunderstanding of the long-term nature of obesity management, or need for regular follow-up with their health care provider. However, discontinuation of these medications has health implications, with a recent study showing weight regain, increased A1c values, increased waist circumference, and increased systolic blood pressures as compared to continued medication use [6]. This cycling on and off recommended medications and the resultant volatility in risk factor control can be mitigated through clear communication and anticipatory guidance provided prior to initiation and throughout treatment. Instead of automatically reciting the medication benefit, understanding the individual concerns and addressing those directly shows the patient that they are being heard, understood, and that their concerns are being considered in the context of their individualized care.

These findings are not unique to GLP-1 RAs. Similar trends are seen with other cardiovascular medications, including statins. In one study of older adults in Denmark taking statins, discontinuation rates ranged from 25% to 30% and was associated with an increased rate of major adverse cardiovascular events (MACE) regardless of whether the statin was used for primary or secondary prevention [7]. A recent publication highlighted the need to better research patient values around treatment and incorporate those preferences into routine clinical care [8]. In the aforementioned study, 75.6% of US participants were unwilling to initiate statin therapy if their baseline 10-year ASCVD risk was 2%, 42.9% were unwilling to initiate statins if their baseline risk was 10%, and 23.6% were unwilling to initiate statins if their baseline risk was 20%. The researchers evaluated the smallest worthwhile difference (SWD) of statins, which represents the patient-reported minimum risk reduction needed for a given treatment to outweigh potential harms. Based on the survey results, the authors concluded that “although willingness increased with baseline risks, fewer than one-third would initiate statins at actual efficacy at thresholds commonly used in guidelines, revealing discrepancies between patient and specialist perspectives”. This study highlights the need for effective communication around individual risk and treatment effects and assessing patient values through routine inquiry and listening. It also emphasizes the need for community-based participation in research and patient representation on guidelines committees to ensure that communication is started upstream in the research process, as opposed to only at time of care delivery. Patient interests should inform their care from early in the process.

In this issue of *Archives of Medical Science*, Domostawska-Żylińska *et al.* show in a survey study of 600 Polish general practitioners an almost universal agreement (98.5%) that physician communication skills are an important component of patient care [9]. Contributions of this study include an evaluation of multiple components of communication, as well as how that relates to a clinician's self-perception of skill level. These findings identify “Listening” and “Giving and Getting Feedback” as two areas of communication that scored the lowest. The authors also noted insufficient awareness of one's own communication skills. These findings were based on self-reporting of communication skills by clinicians, and future studies should incorporate patient input in these outcomes.

Formal training for clinicians in these areas, as well as skills in communicating uncertainty in medical diagnosis and care, could improve patient satisfaction with care received. The authors highlight prior research showing the importance for patients to speak uninterrupted, paying attention to patients, prompting patient questions, utilizing shared decision making, and showing empathy. When done well, caring for patients also means that patients feel cared for. These skills become even more essential in an era where medical misinformation and disinformation is rampant online, and where increasing political polarization influences health behaviors in negative ways.

As new technologies and new ways of communicating with patients are incorporated into medical practice, evaluation of their effectiveness remains crucial. For example, there is consistent evidence that medication adherence is particularly important in individuals with established atherosclerotic cardiovascular disease, however there is limited data on whether text messaging as a communication strategy improves adherence in this population, with some evidence supporting this intervention specifically for those with forgetfulness [10, 11]. This emphasizes what others have logically concluded, which is that interventions aimed at improving adherence must align with individualized barriers and that requires effective communication and partnership between the clinician and the patient [11]. The impact of artificial intelligence (AI) on patient communication is an emerging area of health services research. Ambient listening has been adopted by some health systems, and functions to summarize clinician-patient discussions within clinical documentation platforms, potentially allowing more time for communication during office encounters [12]. Future research should evaluate the long-term impact of new technologies and methods of health care delivery on patient experience, clinical outcomes, and physician satisfaction. Notable settings to

test these new approaches is in the long-term maintenance of GLP1-RAs and statins in primary cardiovascular prevention.

### Funding

No external funding.

### Ethical approval

Not applicable.

### Conflict of interest

The authors declare no conflict of interest.

### References

1. Woodruff J. Dr. Collins reflects on career at NIH, COVID response effort, work on genome sequencing. PBS News Hour. Dec 20, 2021. Accessed April 27, 2026. <https://www.pbs.org/newshour/show/dr-collins-reflects-on-career-at-nih-covid-response-effort-work-on-genome-sequencing>.
2. Keating NL, Gandhi TK, Orav EJ, et al. Patient characteristics and experiences associated with trust in specialist physicians. *Ach Intern Med* 2004; 164: 1015-20.
3. Perlis RH, Ognyanova K, Uslu A, et al. Trust in physicians and hospitals during the COVID-19 pandemic in a 50-state survey of US adults. *JAMA Network Open* 2024; 7: e2424984.
4. Global Burden of Cardiovascular Diseases and Risks 2023 Collaborators. Global, Regional, and National Burden of Cardiovascular Diseases and Risk Factors in 204 Countries and Territories, 1990-2023. *JACC* 2025; 86: 2167-243.
5. Nelson AJ, Pagidipati NJ, Bosworth HB. Improving medication adherence in cardiovascular disease. *Nat Rev Cardiol* 2024; 21: 417-29.
6. Tzang C, Wu P, Luo C, et al. Metabolic rebound after GLP-1 receptor agonist discontinuation: a systematic review and meta-analysis. *eClinicalMedicine* 2025; 90: 103680.
7. Thompson W, Morin L, Jarbøl DE, et al. Statin discontinuation and cardiovascular events among older people in Denmark. *JAMA Network Open* 2021; 4: e2136802.
8. Luo Y, Kawakami H, Funada S, et al. Measuring public preferences for statin therapy using the smallest worthwhile difference. *JAMA Inter Med* 2026; 186: 488-90.
9. Domostawska-Żylińska K, Halik RA, Łopatek MM, Olejniczak D. Patient-centred communication in primary care: are general practitioners aware of their strengths and areas for improvement? *Arch Med Sci* 2026; 22: 642-51.
10. Redfern J, Tu Q, Hyun K, et al. Mobile phone text messaging for medication adherence in secondary prevention of cardiovascular disease. *Cochrane Database Syst Rev* 2024; 3: CD011851.
11. Simon ST, Kini V, Levy AE, Ho PM. Medication adherence in cardiovascular medicine *BMJ* 2021; 374: n1493.
12. North F, Matthews M, Iqbal M. Ambient listening implementation in primary care and changes in electronic health record documentation metrics: pre-post study of an ambient listening tool. *Dig Health* 2025; 11: 1-13. <https://doi.org/10.1177/20552076251403211>.