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“The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician”. This statement of Hippocrates in 400 BC is probably the first emphasis on communication and relation between doctor and patient. The communication between the doctor and patient is one kind of health communication. Health communication is an umbrella term that refers to all aspects of human communication pertaining to health. Health Communication is defined as “a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt, or sustain a behaviour, practice or policy that will ultimately improve health outcomes” (Schiavo, 2007). Health communication employs the concepts of numerous disciplines, including health education, mass and speech communication, marketing, social marketing, psychology, anthropology, and sociology (Bernhardt, 2004; Institute of Medicine, 2003; World Health Organization (WHO), 2003), making it multidisciplinary and multidimensional. The concept of health communication is based on various communication activities or action areas, comprising of interpersonal communications, public relations, public advocacy, community mobilization, and professional communications (Bernhardt, 2004; World Health Organization, 2003). Rogers (1996) defines health communication as “any type of human communication whose content is concerned with health” with the focus on health-related transactions and the factors that influence these.
Health Communication is a trans-disciplinary field that is integral to a variety of fields including public health, health care, global health and community development. Health Communication is commonly understood as a field of theory, research and practice which studies and uses communication strategies, methods, programmes and interventions as a mean to inform and influence patients’ decisions leading to positive health behaviour with a goal of enhanced health. However, in the context of this study, health communication refers to the communication between the doctor and the patient in the process of consultation. Thus, Health Communication, in the context of doctor-patient interaction encompasses the ability to gather information that facilitates accurate diagnosis, to apply appropriate counseling skills which include basic empathy, provide therapeutic instructions in a simple non-technical language so as to be easily comprehensible by the patient, and establish a caring relationship with the patient. These are the core clinical skills to be applied by the doctor in his/her health communication during consultation process so as to achieve the ultimate goal of best treatment outcome and patient satisfaction (Brinkman et al., 2007; Herndon & Pollick, 2002). Health Communication is different from basic communication skills in the sense that processing competence in basic communication skills will not be adequate for the doctor to attain the goal of optimal patient health behaviour and sense of satisfaction in the patient.

Communication is central to understanding human behaviour. The area of health behaviour is no exception. Health communication is an important component in shaping human behaviour to adapt, accept and cope with different health conditions (Berry, 2007). Two important milestones in the history of health communication are the Patients’ Charter (Department of Health, 1992) and the Toronto Consensus Statement (Simpson et al., 1991). The Department of Health (1992, UK) stated that
the patients had a right to be given a clear explanation of any treatment proposed, including the risks involved, and alternative treatment plans. The conference on health communication led to the development of the Toronto Consensus Statement that emphasized on the relationship between communication practices and health outcomes for a positive result. The salient features referred to the fact that communication problems in medical practices are critical and common. It also pointed out the fact that patient anxiety and dissatisfaction are related to uncertainty and lack of information, explanation and feedback and that explaining and understanding patient concerns, even when they cannot be resolved achieves a fall in anxiety. The summary of the Toronto Consensus Statement is a clear call for higher emphasis on psychosocial factors in patient care which gets attention through communication. This can be appreciated by delineating the salient features of the Statement.

1. Doctors often misperceive the amount and type of information that patients want to receive.

2. Improved quality of clinical communication is related to positive health outcomes.

3. Greater participation by the patient in the encounter improves satisfaction, compliance and treatment outcomes.

4. The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information.

5. Beneficial clinical communication is routinely possible in clinical practice and can be achieved during normal clinical encounters, without unduly prolonging them, provided that the clinician has learned the relevant techniques.
The basic elements of doctor-patient communication are to build the relationship, to create a path for the discussion between the doctor and the patient and to gather information about the patient’s problems and issues (Kalamazoo Consensus Statement, Makoul, 2001). The communication between the doctor and the patient is also useful to understand the patient’s perspectives, share information and to mutually decide the plan of action to handle the patient’s problems (Makoul, 2001). A substantial body of evidence shows that effective communication between the doctors and the patients can lead to positive outcomes for patients, for doctors and others. A healthy doctor-patient communication leads to creating a good interpersonal relationship, exchange of information between the doctor and patient, and facilitates the decision-making process (Ha, Anat, & Longnecker, 2010). Effective communication results in improved patients’ health and medical care (Duffy et al., 2004). Studies give evidence that links effective physician-patient communication to desirable health outcomes such as improved adherence to treatment, lower patient stress levels and higher physician satisfaction (Guadagnino & Branch, 2006). In a classic study by Greenfield, Kaplan, Ware, Jr.Yano, and Frank (1985), informing patients and involving patients in the treatment process led to significant reductions in Blood Pressure (BP) and improvements in diabetic control that were comparable with the introduction of new drug. According to Schofield (2004), ‘effective communication was a drug that could be prescribed!’

The ultimate goal of doctor-patient communication is to improve patient’s health and optimize medical care (Duffy et al., 2004). In the contemporary context where the doctor is considered to be service provider and the patient a consumer, patient satisfaction constitutes a prime factor in health care. Research evidence in the past four decades has proved that doctor patient communication plays a pivotal role in
delivery of high quality patient-centered health care (Golin, Thorpe, & DiMatteo, 2007). Such high quality health care cannot be achieved with only professional knowledge and competence because here it is the patient, but not the disease that is seeking health care. The patients will never care how much you know until they know how much you care. In order to ensure high quality patient-centered health care, the essential prerequisite is a shift from biomedical to biopsychosocial approach in diagnosis and treatment (Mead & Bower, 2000). This is because the patient who suffers from a disease and seeks treatment does so in a psychosocial context. It is essential to know if he/she is high on anxiety and depression (which impacts the cognition and thus the memory to be regular with medication) has a social support network of family and friends to aid in therapeutic adherence (that includes diet, exercise and other lifestyle factors) and the economic status to afford the medication and other treatment regimen prescribed. Such considerations can play a role in treatment line only when the doctor-patient communication in the initial consultation is effective to provide an insight to the doctor on the patient’s psychosocial background. Once this is achieved, further process of health care ropes in the patient and family in major decision making which successfully enforces sharing of responsibility on both the patient and the doctor. Such patient-centered care through biopsychosocial approach helps in developing a therapeutic alliance between the doctor and the patient, where inputs on patients’ preferences and physicians’ professional advice receive considerable assessment in the best of optimal outcome. In this process the doctor and the patient develop a bond where the patients’ trust in the doctor goes beyond the perceived components like clinical competence and describes the doctor as supportive and humane. Thus, while endorsing the doctor as a professional the patient also perceives the important human face in the doctor which
is very essential in developing a relationship. Thus, the health communication that takes a biopsychosocial approach forms a reciprocal relationship between the doctor and the patient. Patients’ emotion and attitude towards illness is often traced back to his/her belief system. As per the Health Belief Model (Becker & Rosenstock, 1984), the health behaviour is guided by five constructs, viz. patients’ perceived susceptibility, perceived severity, perceived benefits (of adopting the health behaviour), perceived barriers and cues of action. The health communication, particularly the communication from the health provider has to address all the five aspects related to patients’ belief. In other words, when the doctor explains to the patient the existing health status in terms of seriousness (severity), and vulnerability or risks (susceptibility) a sense of fear is created in the patient that may in turn motivate the patient towards initiation of desirable health behaviour or suspending a behaviour that is considered to cause health hazard.

Further, explanations that highlight the benefits of treatment, adherence, and optimal health behaviour may be perceived as incentives by the patient. Thus, the communication on treatment benefits and the fear of vulnerability functions as push (towards health behaviour) and pull (from the unhealthy behaviour) factors to place the patient on desirable health behaviour path. Supplementary to this, cautioning or forewarning the patient on the possible barrier or hurdles in sustaining health behaviour (for example possible side effects of medicines or alarm signals that warrant emergency consultation) helps in creating a readiness in the patient to circumvent problematic situations. In addition to this some tips from the doctor for sustaining health behaviour (e.g. brining the medicine to the dining table while laying the table) may function as a preventive measure against non-adherence.
To summarize, going by Health Belief Model, in order to address the belief system of the patient, the health communication from the doctor should be parallel to that of a psychological counselor, who aims at cognitive reorientation, emotional ventilation and behavioural change in the client. Similar to the scenario of psychological counseling, the communication of the doctor targeting patients’ health belief model fulfills three important functional goals, viz. exchanging relevant information, initiating interpersonal sensitivity and building a partnership in optimizing the treatment outcomes.

While doctor-patient communication is important in all health contexts, it assumes special significance in the context of chronic illness or Non-Communicable Diseases (NCDs) such as hypertension (HTN), diabetes, etc. These diseases, particularly, HTN is asymptomatic and is called a silent killer. Unless the doctor impresses upon the patient the asymptomatic nature of the disease and the devastating impact it causes on the health, it is very likely that the patient will not understand the importance of compliance. Unless the physicians do not educate the patient on the alarm signals that warrant immediate medical help there is every possibility that the patient ignores them, thus landing in serious and sometimes irreversible adversities such as cerebral hemorrhage and paralysis of the body that may leave the patient permanently handicapped.

Effective doctor-patient communication serves three basic purposes: creating good interpersonal relationship, exchange of information and decision-making pertaining to the health issues (Ong, de Haes, Hoos, & Lammes, 1995). The relationship between the doctor and patient can be better viewed from the perspective of Carl Rogers’ ‘client-centered therapy’. Similar to a psychotherapist, a doctor needs to have few core characteristics in fulfilling the purposes of an effective doctor-patient
communication viz. empathy, respect, genuineness, unconditional acceptance and warmth. Armed with these qualities, a doctor can pave the path for a good inter-personal relationship that will lead to complete exchange of information which in turn will help the doctor and the patient to make informed decisions regarding the medical issues. Empathy in doctor-patient relationship is crucial in eliciting feelings of the patient, and helping the doctor to paraphrase and reflect. An empathic doctor is able to listen to what the patient is saying and more importantly what he/she is unable to say. An ideal doctor-patient relationship is one where there is an integration of both patient-centered and disease-centered approach and that will facilitate exchange of information between the doctor and the patient. The patients come for consultation with information about the symptoms, concerns, etc. while the doctors contribute through their expertise regarding the details of the disease and treatment (Smith & Hoppe, 1991). It is logical that only when there is effective exchange of medical information both from the patient’s and the doctor’s side, informed decisions can be taken for improving the health condition of the patient. Only when there is a shared-decision making where both the doctor and patient are active participants, there is sense of shared responsibility to enhance the health condition.

Effective doctor-patient communication is instrumental for a number of desirable health outcomes. The most important of this is a feeling of satisfaction in the patient. Apart from this, effective communication is also found to reduce psychological distress in patients along with higher rate of symptom redemption and better prognosis (Golin et al., 2007). Studies have proved that direct communication and support have a significant role in reducing visits to emergency department (Bolton, Tilley, Kuder, Reeves, & Schutz, 1991) and control of chronic illness (Tildesey, Mair, Sharpe, & Piaseczny, 1996). An important but often missed out
factor is the terminology involved in the communication process between the doctor and the patient which more often than not has an impact on the patient’s understanding of the doctor’s explanations. Often the doctors fail to remember that individual on the other side may or may not be familiar with the medical “jargons” which the doctors use. Effective communication can be difficult in the best of circumstances. Extensive empirical studies have shown that the patients do not, typically, understand medical terms in the same way as doctors’ (Helman, 1984; Richman, 1987; Freidson, 1988; Lupton, 1994). Patients’ understanding of whatever the doctor is prescribing or advising forms the crux of the doctor-patient communication and of course, the medical regimen. For example, a patient’s understanding of diabetes will definitely not be the same as the doctor’s. When the patient is emotionally distressed, extra effort is required to ensure that the patient accurately perceives what is being communicated. And hence to achieve this, the doctors should focus on helping the patients understand and comprehend the situation they are in and use such words which enhance the patient’s understanding.

The study of doctor-patient communication is based on the idea that patients have unique life histories and perspectives and that taking these perspectives into account leads to improved health outcomes (Zandbelt, Smets, Oort, Godfried, & DeHaes, 2006). Effective communication from doctors in terms of explanation, feedback, sharing of medical data was found to have enhanced adherence in patients (Beck, Daughtridge, & Sloane, 2002; Arora, 2003; Tongue, Epps, & Forese, 2005; Platt & Keating, 2007; Chen et al., 2007). Among all the consequences of doctor-patient communication, the most outstanding effect is seen in the form of adherent behaviour in the patients and subsequently improved prognosis. Adherence is defined as the regularity and punctuality with which the patients takes the prescribed
medication, follows the diet and exercise regimen. While adherence can be said to be the means through which health condition improves, prognosis of the disease is a function of not only the right diagnosis and treatment extended by the doctor but it is equally determined by the compliance with the treatment and health behaviour of the patient or health-seeker. Prognosis is defined as the outcome of treatment in terms of clinical symptoms as well as objective measures such as BP reading. While improved adherence is seen as a direct effect of effective doctor-patient communication, the impact on prognosis takes a pathway through various immediate and intermediate outcomes like patient’s understanding, patient satisfaction, quality of decision-making, commitment to treatment, trust in the system and most importantly increased adherence to the treatment regimen.

Adherence to clinical therapy forms an important component of health behaviour and is the major health outcome and critical parameter of the health care services. Adherence is defined as the extent to which patients take drugs as prescribed by their health care providers (Osterberg & Blaschke, 2005). A major contributor of healthcare costs is non adherence or partial adherence to treatment regimen (Dunbar-Jacob & Schlenk, 2001) which is described as the extent to which a person’s health behaviour does not coincide with the health or medical advice (Vermeire, Hearnshaw, VanRoyen, & Denekens, 2001). The rate of adherence is usually measured in terms of percentage of medication actually taken by the patient over a specified period of time (Osterberg & Blaschke, 2005).

Adherence can be understood with better clarity with reference to non-adherence. Non-compliance or non-adherence on the other hand refers to the patient’s ignoring, forgetting, or misunderstanding the regimen as directed by the medical professional and thus carrying it out incorrectly or not at all (Dimatteo & Martin,
The potential benefits of treatment regimen are negated because of poor adherence. Poor adherence may lead to further complications and result in poor prognosis. For instance, poor adherence to anti-hypertensive medication may lead to stroke, renal failure for which further treatment is required. Adherence to medication is different from therapeutic adherence which means adherence to prescribed diet, exercise, or lifestyle changes along with prescribed medication (Jin, Sklar, Oh Sen, & Li, 2008).

Medication non-adherence is the extent to which a person’s behaviour does not coincide with medical or health advice. It is now accepted as a public health issue and was estimated to cost $100 billion, contributing to nearly 125,000 deaths each year in the United States (Vermeire et al., 2001). Non-adherence to medication and lifestyle regimes in chronic diseases have been found to be associated with increased hospitalizations and mortality (Ho et al., 2006), yet many patients fail to adhere to treatment recommendations (Cramer, 2004). The prevalence of medication non-adherence as well as the cost associated with it is immense. Though it is very significant, concrete statistics on India patients on these aspects are not available. It is important to understand the causes for non-adherence. Sustained level of optimal adherence to the treatment regimen is of utmost importance in the context of disease management, more so in case of NCDs or chronic illnesses which involves life-long dependency on pharmacotherapy. The ramifications of poor adherence or non-adherence in chronic illnesses are severe and in many cases fatal too. In the effective management of chronic illnesses like diabetes, arthritis, HTN, etc. adherence to the prescribed treatment regimen plays a crucial role, along with lifestyle changes like diet control and physical exercise.
The contemporary global scenario presents a paradigm shift in the nature of health concerns, with the developing countries joining the developed countries in a progressive increase in the incidence of NCDs. Chronic illness or NCDs like diabetes, HTN, asthma, cancer or HIV/AIDS which are also called lifestyle diseases are found to have become a prime health concern globally and particularly in Indian context.

The NCDs are viewed as epidemic posing the greatest global challenge to the 21st Century (Murray & Lopez, 1996; Reddy, 2003). Collectively, NCDs account for 63% of all deaths worldwide with 80% of those taking place in developing countries (Narayan, Ali, & Koplan, 2010; WHO, 2013a). According to a report by WHO (2002), it is expected that chronic diseases will account for 73% of deaths and 60% of the global disease burden by 2020, and also for major percentage of diseases and death in India. This trend is likely to continue given the growing urbanization, increased economic levels, and disintegration of informal social support, sedentary job requirements and increased vulnerability to stress.

Among the NCDs, HTN is found to have affected 20-40% of the urban population and 12-17% of the rural adults (Reddy, Shah, Varghese, & Ramadoss, 2005). HTN is a chronic condition where the BP remains at an elevated level beyond 120/80 mm Hg of systolic and diastolic readings respectively. Because of its asymptomatic characteristic a significant numbers of individuals who have HTN are unaware of their condition. Being asymptomatic increases the risk factor in hypertensive patients making it fatal. The complications associated with HTN include heart attack, congestive heart failure, brain stroke, kidney failure, peripheral artery disease, and aortic aneurysms (weakening of the wall of the aorta, leading to widening or ballooning of the aorta), and retinal hemorrhage. Of those who are diagnosed, the treatment is often inadequate (Kearney, Whelton, Reynolds, Kristi, Whelton & He,
The prevalence of HTN in developed countries shows that 25% of urban population and 10% of rural population have HTN. This roughly amounts to 31.5 million rural and 34 million urban populations suffering from HTN. Of this 70% are estimated to be in Stage 1 which carries a significant cardiovascular risk (Gupta, 2004). According to a study by Das, Sanyal, and Basu (2005) out of 35.8% of participating subjects having pre-hypertensive systolic BP (120-139mm of Hg) and 47.7% sharing pre-hypertensive diastolic BP ranging between 80-89mm of Hg, 40.9% were found to have systolic HTN and 29.3% were found to have diastolic HTN. India is witnessing an alarming rise in the prevalence of chronic diseases like HTN, diabetes, etc. over-burdening the country’s health care system in terms of economy, productivity and quality of life of the population. HTN is one such chronic disease which is becoming an epidemic in the world. Around 1.5 million deaths occur annually due to cardiovascular diseases (Gaziano, Reddy, Paccaud, Horton, & Chaturvedi, 2006), out of which HTN is directly responsible for 57% of all stroke deaths and 24% for all coronary heart diseases death (Gupta & Gupta, 2009). In 90% of people with HTN, the etiology of high BP is not known and is referred to as primary or essential HTN. In an analysis of worldwide data, Kearney et al. (2005) reported the number of hypertensive adults in 2000 was 972 million worldwide, 50% of them being from developing countries. The report also predicted that the number is likely to increase by about 60% by the year 2025 to a total of 1.56 billion.

HTN is identified as a disease closely associated with lifestyle. The treatment package includes lifelong anti-hypertensive medication, regulated diet, adequate physical exercise and efficient stress management. Every dimensions of this treatment package is vital in view of the high cardiovascular risk involved in the condition. To ensure strict adherence to the treatment regimen the health communication from the
doctor has to be highly efficient from the stage of taking the history to the stage of treatment follow up. The doctor has to explain to the patient, in non-technical language the present state of health, the need for strict adherence to medication, diet and exercise and the role of each of them in keeping the BP under control, the repercussions of non-adherence in terms of high vulnerability to cardiovascular disease.

In addition to this, the doctor also must motivate the patient not only to initiate but also to sustain strict adherence. This can be done by feedback techniques where the doctor gives his/her feedback on the prognosis in every review visit of consultation.

The physicians must incorporate the communication practice because owing to the high prevalence of HTN where the patient finds almost every third or fourth person hypertensive, and because of the very asymptomatic nature of the disease, there is every probability for the patient to get complacent about adherence to treatment. Research evidence established a strong positive relationship between doctor-patient communication and its impact on patient adherence to anti-hypertensive medication, maintenance of lifestyle change and control of BP. Jolles, Clarke and Braam (2010) highlighted the fact that poor doctor communication is correlated with higher risk of non-adherence. They advocated that in case of hypertensive patients, effective communication from doctor must ascertain three aspects viz. patient’s comprehension, acceptance and translation into action with respect to medical advice. Further these should be followed up for long term retention. The role of the doctor is very crucial in creating a sound cognitive base in the patient. Hence the responsibility of verifying correct comprehension of the shared communication, the commitment of the patient to adhere to medical advice and
helping the patient to translate the commitment to action is the responsibility of the doctor. This demands enormous health communication skill on the part of the doctor, whose influence on the patient has a stimulating impact to get involved in communication process. Naik, Kallen, Walder, Richard and Street (2008) in their study identified three common factors in communication between the doctor and patient significantly associated with control of HTN. They are the doctor’s decision making style patient’s proactive communication and the doctor’s collaborative communication in setting treatment goal, which, in combination impacted the control of HTN. The pathway analysis indicated that the doctor’s collaborative communication in setting the treatment goal cast an indirect impact on HTN control through the doctor’s decision making and the patient’s proactive communication which directly predicted the HTN control.

The research evidence clearly indicated the high impact that doctor-patient communication casts on the management of diseases in general, and HTN in particular. At the same time the scientific pragmatism demands that there is also a need to assess the condition in which the efforts are invested to optimize doctor patient communication quality. A recent Indian statistics reveals that India because of its dramatic doctor patient ratio of 1:1800 (Deo, 2013) is listed under countries with critical shortage of health service providers. The average time a physician interacts with a patient is progressively shorter across the globe and more so in India. While the reason in Indian scenario can be attributed to the disproportionately large number of patient the doctor has to see in a day compared to his/her counterpart in the west, one cannot ignore the fact that technology dependence in health care is compelling the doctors to distribute the time between the patients and computers and other electronic gadgets. This has reduced the average doctor-patient interaction time to something
between two to ten minutes. Given these circumstances attempts at quality communication intervention remains a challenge.

Health communication is a skill and hence one can acquire and improve through training programmes. Travaille, Ruchinskas, and D’Alonzo (2005) discussed the salient major aspects to be covered in training or health education. They strongly recommended that the doctors gather adequate information on the patients’ existing knowledge base so as to build upon that. They opined that there should be a match between the information the patient desired to have and the information the doctor provides. This helps in avoiding information overload or deprivation. Further they recommended that the context of communication should be accompanied with empathy at a pace that suits the patients’ cognitive capacity and emotional state. The training must necessarily include the skills of reading patients’ non verbal communication, and communication in non-medical language. In addition, there should be adequate emphasis on the act of communicating the truth while holding on to being hopeful. While applying all these skills the doctors, just as counselors, must also be trained to be prepared for and encounter patient reactions.

Given the Indian context of doctor-patient ratio, it may not be feasible to expand the consultation time to match the western standards, but the real challenge lies in optimal utilization of the available time with quality communication. It may be pertinent to mention here that for the purpose of the existing baseline level of communication, there is a need to standardize the method of measuring doctor-patient communication. Identification of a valid method of measuring communication is also a prerequisite to facilitate a process that is predictive in estimating patient adherence and prognosis through doctor-patient communication.
Past researches adopted varied methods in quantifying doctor-patient communication. A number of studies measured the quality of communication based on patient satisfaction while a few studies approached doctor-patient communication from what the doctor informed the patient. There are studies which measured the health literacy of patients by measuring the patient’s comprehension of technical expression used by the doctor. The recent attempt to quantify communication between the doctor and patient is computer assisted quantitative measures of words used in the communication during consultations. However, while developing a method to measure doctor–patient communication the most critical aspect related to reliability and validity to endorse that communication is a two way process. Hence the quantification remains incomplete as long as it restricts the input to either the initiator or the receiver. A holistic approach in evolving a measurement of communication must take into account whether and to what extent the intended communication of the perpetrator (doctor) has been received by the listener (patient). When it comes to health communication between the doctor and the patient with HTN, what determines the quality is when the doctor includes all aspects to create a cognitive base such as the present condition, schedule of medication, restriction on diet, significance of exercise, need for self monitoring, time of review visit and alarm signals for emergency consultation, and the patient endorses that such information is communicated by the doctor and that it is understood by him/her. The entire communication with the extent of mutuality can quantify the transaction of information and determine the quality of communication. Only when the communication is thus measured in its entirety, it would be meaningful to inquire into its impact on adherence and prognosis. If the quality of communication between the doctor and the patient of HTN is enriched, it can prevent medical emergencies and
cardio-vascular deaths in large proportion that is happening mainly because of the progressive increase in the incidence of HTN.

According to data in Global Burden of Diseases, Injuries and Risk Factors, published by Lancet, it was reported that by the end of 2008, there were 139 million hypertensive patients in India, contributing to 14% of the global disease burden of uncontrolled HTN (Lim et al., 2012), leading to increased associated cardiovascular risks. In addition to the above, India is now faced with the risk of increasing prevalence of pre-hypertensive population and the chances of that section of population developing HTN at a later stage is high. In a recent study by Yavagal et al. (2013), it was reported that 45% of the urban population are prehypertensives and live with a high risk of developing HTN in the future. The researchers also reported that almost 47.4% of the urban population in Chennai, 44.3% in Kerala and 50% in West Bengal are prehypertensives. The risk of the prehypertensives turning into patients with HTN looms large. Hence providing the necessary health care services will be challenging task. Issues like huge population, low levels of health literacy and high patient-doctor ratio plague the Indian health care system which falls short of providing a holistic approach to disease management, prevention of diseases, and promotion of health. In this scenario, effective doctor-patient communication takes a back seat. In the backdrop of over-burdened Indian health care system and rising prevalence of chronic diseases and to lay down a greater emphasis on promotion of effective health communication aspect in the management of chronic illnesses which are becoming epidemics in the country, the present study was undertaken. An extensive review of past research findings is presented in the next section.