International Journal of Multidisciplinary Research And Studies

Available online at https://ijmras.com/

INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH AND STUDIES
ISSN: 2640 7272
Volume:04; Issue:01 (2021)

Page no.- 15/15

WAYS OF ENFORCING ADHERENCE TO REGIMENS IN PATIENTS WITH EATING DISORDERS

Premshila Kumari

M.Phil., Roll No.: 150598 Session-2014-15
Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India
E-mail: premshilaku08@gmail.com

ABSTRACT

The discipline of health communication is one that crosses disciplinary lines and plays an important role in many other areas of study, such as public health, health care, global health, and community development. Health communication is a field of theory, research, and practise that studies and uses communication strategies, methods, programmes, and interventions as a means to inform and influence patients' decisions leading to positive health behaviour with the goal of enhanced health. The term "health communication" is used interchangeably with "health communication theory" and "health communication research." On the other hand, for the purposes of this investigation, the term "health communication" refers to the dialogue that takes place between the patient and the physician throughout the consultation process. Therefore, health communication, in the context of doctor-patient interaction, encompasses the ability to gather information that facilitates accurate diagnosis, to apply appropriate counselling skills that include basic empathy, to provide therapeutic instructions in a simple non-technical language so that they are easily comprehensible by the patient, and to establish a caring relationship with the patient.

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Keyword: Health Communication, Non-Technical Language, Consultation Process,

INTRODUCTION

Additionally, health communication encompasses the ability to establish a caring relationship with the patient. These are the fundamental clinical skills that need to be utilised by the physician in the course of the consultation process in order to accomplish the ultimate aim of the best possible outcome for the therapy being provided and the highest level of contentment for the patient (Brinkman et al., 2007; Herndon & Pollick, 2002). Basic communication skills are not sufficient for a doctor to achieve the goal of optimal patient health behaviour and a sense of satisfaction in the patient.

This is where health communication differs from basic communication skills: processing competence in basic communication skills is not sufficient for a doctor to achieve this goal. Understanding human behaviour requires a strong grasp of the importance of communication. Not even in the realm of healthy behaviours can we break this rule. Communication about health is an essential component in the process of moulding human behaviour in order to accommodate, accept, and manage a variety of health issues (Berry, 2007). The Patients' Charter (Department of Health, 1992) and the Toronto Consensus Statement both represent significant turning points in the annals of health communication's long and illustrious history (Simpson et al., 1991). The United Kingdom's Department of Health declared in 1992 that patients had the right to be provided with a comprehensive explanation of any therapy that was being offered, including the risks that were associated with the treatment as well as alternative treatment options. The conference on health communication resulted in the creation of the Toronto Consensus Statement, which placed an emphasis on the link that exists between communication methods and health outcomes with the purpose of producing a favourable outcome. The most notable characteristics linked to the fact that communication issues in medical practises are both serious and quite frequent. It was also brought to light that patient anxiety and discontent are linked to ambiguity as well as a lack of information, explanation, and feedback; and that addressing and comprehending patient concerns, even if those issues cannot be answered, results in a reduction in patient anxiety.

The executive statement of the Toronto Consensus Statement makes it abundantly obvious that more attention should be paid through communication to the psychological variables that are involved in the treatment of patients. This can be understood better by examining the

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Statement in more detail and focusing on its most important aspects. 1. Medical professionals frequently have an inaccurate understanding of the quantity and kind of the information that their patients want. Positive changes in health outcomes are associated with increases in the quality of clinical communication. Patient happiness, patient compliance, and treatment results all increase when patients are encouraged to take an active role in their care. Patients who believe they have gotten sufficient information report a lower degree of psychological suffering than those who do not believe they have received sufficient information. Beneficial clinical communication is routinely achievable in clinical practise and may be accomplished during typical clinical encounters, without unreasonably delaying them, as long as the clinician has acquired the essential procedures. This is only the case if the physician has been trained. Building a connection, paving the way for a conversation to take place between the doctor and the patient, and gathering knowledge about the patient's concerns and challenges are the fundamental tenets of effective doctor-patient communication (Kalamazoo Consensus Statement, Makoul, 2001). Communication between the patient and the physician is beneficial for a number of reasons, including the ability to comprehend the patient's viewpoints, the exchange of information, and the joint decision-making on a course of action to deal with the patient's issues (Makoul, 2001).

There is a significant body of data that demonstrates how excellent communication between patients and their doctors may lead to great results, not just for the patients but also for the physicians and other parties involved. The establishment of a positive interpersonal relationship between the doctor and patient, the sharing of information between the two parties, and the streamlining of decision-making all result from effective communication between the two parties (Ha, Anat, & Longnecker, 2010). The improvement of patients' health and the quality of medical treatment that emerges from effective communication (Duffy et al., 2004). Studies provide data that establishes a relationship between efficient physician-patient communication and favourable health outcomes such as greater adherence to treatment, decreased levels of patient stress, and higher levels of physician satisfaction (Guadagnino & Branch, 2006). Greenfield, Kaplan, Ware, Jr. Yano, and Frank (1985) conducted a seminal study in which they discovered that 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 to the introduction of new drug. "Effective communication was a medicine that could be administered," as stated by Schofield (2004).

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

The most important objective of doctor-patient communication is to enhance the health of the patient and provide the best possible medical treatment (Duffy et al., 2004). In the modern setting, in which the patient is seen as a customer and the doctor as a supplier of a service, the level of satisfaction that a patient has with their care is an extremely important aspect of health care. The findings of several studies conducted over the course of the past four decades have conclusively demonstrated that open and honest communication between patients and their physicians is an essential component of the provision of high-quality, patient-centered medical care (Golin, Thorpe, & DiMatteo, 2007). Because it is the patient, and not the sickness, that is seeking medical attention, it is impossible to provide treatment of such a high level using simply professional knowledge and skill. Patients won't care how much you know until they realise how much you care about them, regardless of how much knowledge you have. A transition from a biological to a biopsychosocial approach in the diagnosis and treatment of patients is a crucial requirement for providing high-quality patient-centered health care, which is the focus of this article (Mead & Bower, 2000).

This is due to the fact that a patient who is afflicted with an illness and seeks therapy does so within the framework of their psychological environment. It is essential to know if the individual suffers from high levels of 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 assist in therapeutic adherence (that includes diet, exercise, and other lifestyle factors), and has the economic status to afford the medication and other treatment regimen that has been prescribed. Such factors are only able to have an impact on the treatment plan if the communication between the physician and patient at the initial consultation is clear enough to provide the physician an understanding of the patient's psychosocial history. When this goal is accomplished, the next step in the process of providing medical care involves including the patient and their family in significant decision making, which successfully enforces responsibility sharing on both the patient and the treating physician. This type of patient-centered care, which is accomplished through the use of a biopsychosocial approach, contributes to the formation of a therapeutic alliance between the patient and the physician. Within this alliance, inputs on patient preferences and professional advice from physicians are given considerable consideration in order to achieve the best possible outcome. In the course of this procedure, the physician and the patient build a relationship in which the patient's confidence in the physician extends beyond the apparent qualities of the physician, such as clinical competence, and instead describes the physician as being supportive and

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

kind. Therefore, while the patient recognises the doctor as a trained professional, the patient also recognises the significant human face that the doctor possesses, which is extremely crucial in the process of creating a connection.

Therefore, communication in the medical field that adopts a biopsychosocial perspective establishes a mutually beneficial relationship between the patient and the attending physician. It is frequently possible to connect a patient's mood and attitude toward sickness back to the patient's underlying belief system. According to the Health Belief Model developed by Becker and Rosenstock in 1984, a patient's health behaviour is influenced by five different constructs. These constructs include the patient's perceived susceptibility, perceived severity, perceived benefits (of adopting the health behaviour), perceived barriers, and cues of action.

The communication about health, particularly the information that comes from the health professional, has to cover all five factors that are connected to patients' beliefs. In other words, when a doctor explains to a patient the existing health status in terms of seriousness (severity), and vulnerability or risks (susceptibility), a sense of fear is created in the patient, which may, in turn, motivate the patient towards the initiation of desirable health behaviours or the suspension of behaviours that are considered to cause health hazards. In other words, fear can motivate patients to initiate behaviours that are desirable for their health or to suspend behaviours that are considered to cause health hazards. In addition, explanations that emphasise the advantages of therapy, adherence, and good health behaviour may be seen as incentives by the patient. Therefore, the communication on treatment advantages and the fear of vulnerability serves as push (towards healthy behaviour) and pull (away from unhealthy behaviour) elements to set the patient on the preferred route of healthy behaviour for themselves. In addition to this, cautioning or forewarning the patient on the possible barrier or hurdles in maintaining healthy behaviour (for instance, possible side effects of medicines or alarm signals that warrant emergency consultation) helps in creating a readiness in the patient to avoid or get around problematic situations. This can help the patient avoid or get around potentially dangerous situations. In addition to this, certain recommendations from the physician for maintaining healthy behaviours (such as bringing the medication to the dinner table when setting the table) may be able to serve as a preventative strategy against non-adherence. 8 To summarise, according to the Health Belief Model, in order to address the belief system of the patient, the health communication that is provided by the doctor should be parallel to that of a psychological counsellor, who aims at cognitive reorientation, emotional ventilation, and behavioural change in the client.

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

REVIEW OF LITERATURE

The phrase "health communication" can refer to a variety of different things. The meaning of "Health Communication" changes depending on the setting in which it is considered, and its value is determined by how well it functions; this results in a number of distinct meanings. The core of health communication is communication in the context of health that refers to the sharing of meanings or exchange of information, informing and persuading individuals or groups, inspiring people to change behaviours, and that supports and maintains the change. Numerous scholars and organisations, in response to the increasing significance of health communication (Parrott, 2004), have presented a variety of meanings of the term "health communication." "the study and implementation of communication methods to inform and influence individual decisions that promote health," is how the Centers for Disease Control and Prevention and the National Cancer Institute describe "health communication." The process of health communication seeks to change the behaviour of individuals as well as communities in order to improve the health of such people and communities. Throughout addition to informing and influencing, this purpose is pursued in the process.

Clift and Freimuth (1995) provided a definition that encapsulates this idea when they stated, "Health communication, like health education, is an approach that attempts to change a set of behaviours in a large-scale target audience regarding a specific problem in a predefined period of time." This statement captures the essence of what health communication is all about. Motivating individuals and communities is an important component of health communication, since it is necessary to bring about a change in behaviour at the level of the person as well as the community. This is mirrored in the definition that Ratzan, Sterans, Payne, Amato, and Madoff have provided for the term (1994). According to what they said, "health communication" refers to "the art and method of informing, persuading, and inspiring individual, institutional, and public audiences about essential health concerns." Its purview encompasses activities such as the reduction of the incidence of disease, the promotion of health, the development of health care policy and business, and the improvement of people' quality of life and overall health within a community.

The dissemination of information on health and illness to the general populace is the objective of the field of health communication. In order to do this, the communication and dissemination of health-related information is essential. The very essence of health communication is two-way dialogue, and it is more common in a one-on-one context. This applies appropriately in a doctor-patient communication set-up where the interchange of

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

information benefits both the doctor in his or her diagnosis and the patient by facilitating appropriate medical advice. Communication Between Patients and Healthcare Professionals The provision of the highest-quality care that may possibly be must be the primary focus of every health care delivery system. In this day and age, when medical technology has progressed and holistic health is promoted in a big way, and when patients as health seekers have every right to demand the best possible care in hospitals, the onus of providing the aforementioned becomes the responsibility of the health care professionals. Patients have every right to demand the best possible care in hospitals. Every health care delivery system revolves around the relationship that exists between patients and their respective medical practitioners.

RESEARCH METHODOLOGY

PLAN AND DESIGN

The primary purpose of this research was to investigate the effects of health communication between primary hypertension patients and their treating physicians on the patients' adherence to treatment and the prognosis of their condition.

The research was designed to be conducted in two stages so that it could accomplish this goal. During Phase I, the Quality of Health Conversation was evaluated on the basis of the initial communication between the doctor and patient that took place during the consultation. During the consultation, the therapeutic adherence of the patients who were diagnosed with primary HTN was also evaluated. Readings of the patient's blood pressure were also collected as a baseline for the evaluation of the patient's prognosis. Six weeks following the conclusion of the first phase, the patients returned to the physicians for an examination. This consultation was part of the second phase of the investigation. During Phase II of the study, the patients were evaluated by the doctors in terms of their prognosis based on the clinical symptoms that they reported (as reported by patients). Readings of the patient's blood pressure were also taken throughout this time. Consequently, evaluation of the prognosis was the focus of Phase II of the study, whereas Phase I of the study focused on assessing the quality of communication.

The correlational design was utilised for the most part in this study, and the Quality of Communication was utilised as a predictor of Adherence and Prognosis. After that, adherence was also considered a potential indicator of the prognosis.

The research also included a between-subjects design to find out the effect of Quality of

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Communication (High, Medium, and Low) on the level of Adherence, Prognosis (as measured by doctors' ratings), in patients with primary HTN, and also to find out the effect of level of Adherence (High, Medium, and Low) on prognosis. These two aspects of the research were carried out in order to determine the optimal treatment for patients with primary HTN. Along with this, a 3X2 Simple Mixed Factorial design was utilised. selected to determine the influence that Quality of Communication (between-subjects) has on Prognosis by comparing blood pressure measurements taken before and after the Adherence Phase in the study. Studying the influence of different levels of adherence (high, medium, and low) on prognosis as determined by blood pressure measurements was carried out using the same methodology. In this study, "Health Communication," which refers to the communication that takes place between the patient and the doctor, was defined as the explanation that the doctor gives to the patient about the current condition of the patient in comparison to the norm, the need for and schedule of medication, diet, and exercise, the risks associated with not adhering to these things, the follow-up schedule, and the alarm signals that warrant the patient to visit the doctor, as well as the patient's level of comprehension of the same information. The degree to which the patient understood the doctor's explanation was a significant factor in determining the Quality of Communication.

Patient adherence has been operationally defined as the regularity, with which the patient takes the prescribed medication, adheres to the restrictions of diet and sticks to the restrictions of the duration and type of exercise, and the punctuality with which the patient makes the review visits to the doctor.

The prognosis was operationally defined as the relative condition of the patient in comparison to that of pre-Adherence Phase in terms of BP readings and doctor's ratings on the reported clinical symptoms such as palpitation, breathlessness, headaches, heaviness in the head, swelling in the foot, and free urination, etc. Prognosis was operationally defined as the relative condition of the patient in comparison to that of pre-Adherence Phase in terms of blood pressure readings

Participants At first, the sample for this investigation was composed of thirty different nests. The survey approach was utilised to compile the 30 groups that were included in the study. Within each of these groups, there was one doctor and ten main HTN patients. The word "nest" gives the impression that every community is a unit in which one physician was responsible for the care of 10 patients and was required to meet all of the patients' medical requirements.

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

DATA ANALYSIS

INTRODUCTION

The findings investigated how the quality of communication between a doctor and a patient influences adherence and prognosis, with the quality of communication serving as the independent variable in the analysis, while adherence and prognosis served as the dependent factors. In addition, the effect of patient adherence in the prediction of prognosis was explored in this study. In this particular study, the independent variable was patient Adherence, and the dependent variable was Prognosis. In-depth research on Adherence was conducted by first examining Adherence to Medication, then Adherence to Diet, then Adherence to Exercise, and finally Adherence to Self-monitoring, in addition to total Adherence. A study was done on the prognosis, and it took into consideration the overall evaluations given by doctors based on the clinical symptoms that were reported by patients. Additionally, systolic and diastolic blood pressure measurements were taken before and after the adherance phase. Analyses were performed using ANOVA and post-hoc analyses using Tukey's Tests of HSD to determine the effect of the quality of communication on adherence and prognosis.

The quality of communication between the doctor and patient was used as the independent variable in these studies, and the prognosis of the disease and the adherence of the patient to their treatment were used as the dependent variables. In order to investigate the connection between the doctor's Quality of Communication and Adherence as well as Prognosis, contingency tables were developed and chi-square tests of independence were carried out. Using ANOVA and post-hoc analysis (Tukey's Tests of HSD), more research was conducted in order to investigate the function that Adherence plays in predicting the prognosis of the disease. Following this, an attempt was made to discover elements that contributed to doctor-patient communication, patient adherence, and disease prognosis by performing regression analyses.

This was done in order to better understand the relationship between doctors and patients (Simple and Multiple). After that, other attempts were made. conducted to determine if or whether there is a connection between the quality of communication between doctors and patients and the prognosis. In this chapter, both the statistical studies that were conducted in order to accomplish the aforementioned objectives and the findings in their entirety are provided. The software that was utilised for the analysis of the data was version 19.0 of the

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Statistical Package for the Social Sciences (SPSS). On the pages that follow, you will find a presentation of the results.

The discussion of the outcomes is broken up into four sections. In the first section, the index that was designed to quantify the quality of communication between doctors and patients is discussed. In addition, the significance of the quality of communication in terms of patient adherence and the prognosis of disease is discussed. In the second section, the methodology that was developed to evaluate the Quality of Communication of individual physicians is discussed, as well as the categorization of patients who were treated by physicians with High, Medium, or Low Communication Quality.

In this section, the influence that the quality of communication between physicians and patients has on a patient's adherence and prognosis was investigated. In the third and last section, we investigated how the amount of adherence affects the prognosis. In the last section, often known as the fourth part, the elements that may be used to predict the quality of communication, adherence, and prognosis are discussed. The presentation of the assessment of the respective contribution of Quality of Communication and Adherence in Prognosis while trying to trace a pathway brings this part to a close.

DOCTOR–PATIENT COMMUNICATION QUALITY SCORES: SIMILARITY INDEX

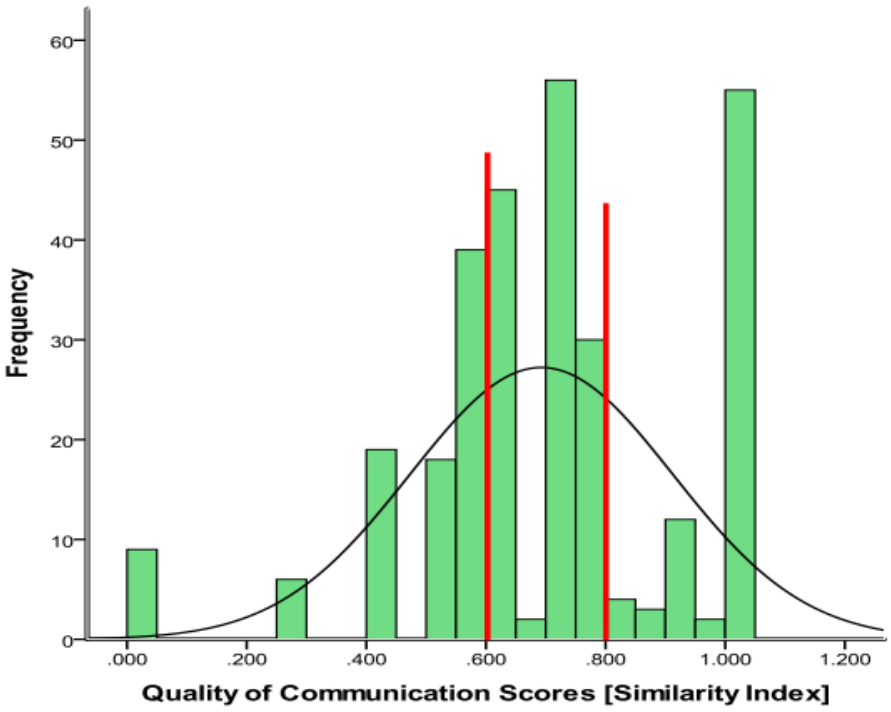
The first thing that needed to be done in the findings section was to measure the quality of communication between the doctor and the patient. This is because the study is about the quality of communication. The research gap that existed in terms of assessing communication in its whole was filled by the method of quantification of the quality of communication that was used in this study. The results of previous studies have been measured the quality of the communication from either the perspective of the one doing the communicating or the person being communicated to. Because this research took into account the two-way nature of communication, it was able to quantify communication in a manner that was more comprehensive.

It was of the utmost importance to devise a method for measuring the quality of communication that involved comparing the communication that was intended with the communication that was actually received. This was accomplished by assigning points to the HCC forms that required responses from both the patient and the treating physician. The investigator used two checklists of the same form, one of which was completed by the doctor

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

and made reference to the communication that was directed from the patient to the doctor, and the other of which was completed by the patient and made reference to the communication that they had received from the doctor. Every item that was ticked off by the relevant responder was given a score of one point. The replies were comparable to one another. When both the patient and the doctor checked the same box on a certain issue, that item was given a score of 1 from both of the respondents. When both the patient and the doctor have a score of 1, we say that there has been matched communication between the two parties.

In the event that there is a breakdown in communication between the patient and the doctor, their scores will either be 1 and 0 or 0 and 1, respectively. The statistical method known as the Similarity Index (SI) was utilised in order to measure the Quality of Communication by including the scores of both the doctor and the patient. The similarity index (SI) measures the degree to which two different sets of participants' answers are comparable when assessing the same variable. In the current investigation, the similarity index (SI) of replies was computed between the responses of the doctors and the responses of the patients on each and every item of the HCC. The scores that are used to determine the quality of communication are shown by the values of SI. The methodology and steps involved in arriving at the final ratings for Quality of Communication are broken down in great depth and included (Appendix II).



Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

depicts the distribution of scores of Quality of Communication for thesample (N = 300)

The procedure of binning was used to categorise the quality of communication data once it was determined how the values of SI were distributed. Scores on the quality of communication that had a similarity index score of 0.80 or above were categorised as belonging to the High Communication Quality group (the right part of the figure). According to this, patients who fell into this category had a comprehension level of around 80.1% of the conversation that took place between the doctor and the patient. The patients who received communication scores ranging from 0.601 to.800 were classified as having a medium quality of communication, which is represented by the middle portion of the figure. This indicates that the patients in this group understood and comprehended between 60.1% and 80% of the communication that took place between the doctor and the patient. If a patient had a communication score that was less than or equal to.600 (shown by the left side of the figure), it meant the patient could grasp less than sixty percent of what the physician conveyed to them. As a result, the Quality of Communication has been rated as being rather poor for this particular group. The results may be seen in Table 4.1 based on the similarity indexes of the Quality of Communication between patients and physicians, groups displaying high, medium, and low levels of communication were shown.

Table 4. 1 Distribution of patients into three groups of Quality of Communication

Quality of Communication Group	Quality of CommunicationScores	n
High	≥.801	76 (25.3)
Medium	.601 - .800	133 (44.3)
Low	≤.601	91 (30.3)
Total		300

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Note. n = number of patients; Figures in parentheses represent the percentages

Table 1 reveals that out of a total of 300 patients, 76 patients (25.3%) were assigned to the High Communication Quality group, whereas 91 patients (30.3%) belonged to the Low Communication Quality group. This information can be seen by examining the table. It was discovered that 133 patients, or 44.3 percent of the total, fell into the category of having a communication quality that was rated as medium.

CONCLUSION

The study further proved that the BP readings of patients with high adherence levels dropped significantly between the two consultations with a gap of six weeks. The fact that the BP readings of patients with high level of Adherence was found to be significantly lower between the pre-post Adherence Phase compared to those belonging to lower Adherence group is a testimony of the role of adherence in managing primary hypertension. In a nutshell the study reiterated that adherence is an essential health 172 behavior for effective management of primary hypertension. The hypothesis that Adherence will have a determining effect on Prognosis is accepted. When the significance of Adherence is categorically proved time and again by several researchers, it is pertinent to investigate the antecedents of Quality of Communication and Adherence. The results of the study as indicated by regression analyses revealed that out of seven variables tested, only one variable namely, Patient Category was found to contribute significantly to Quality of Communication. Patient Category refers to the time of their first consultation with the doctor i.e. old and new patients. Patients who had already consulted the doctor before the data collection was started in that hospital were called the old patients, while the patients who came for their first consultation after initiating the study in that hospital were called new patients.

REFERENCES

1. A.A., & Hasab, A.A. (2011). Prevalence of elevated blood pressure and association with obesity in Egyptian school adolescents. International Journal of Hypertension, 2011, 952537. doi: 10.4061/2011/952537.
2. Allen, S.M., Petrisek, A.C., & Laliberte, L.L. (2001). Problems in doctor-patient communication: the case of younger women with breast cancer. Critical Public

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

Health, 11(1),

3. Anden, A., Andersson, S. O., & Rudebeck, C. E. (2005). Satisfaction is not all: Patients‟ Perception of outcome of general practice consultations, a qualitative study. BMC Medical Practice, 6(43).
4. Arora, N. (2003). Interacting with cancer patients: the significance of physician‟ communication behavior. Social Science & Medicine, 57(5),
5. Asnani, M.R. (2009). Patient-physician communication. West Indian Medical Journal, 58(4),
6. Atkins, L., & Fallowfield, L. (2006). Intentional and non-intentional non-adherence to medication amongst breast cancer patients. European Journal of Cancer, 42(14),
7. Bacon, S.L., Sherwood, A., Hinderliter, A., & Blumenthal, J.A. (2004). Effects of exercise, diet and weight loss on high blood pressure. Sports Medicine, 34(5),
8. Barber, N., Parsons, J., Clifford, S., Darracott, R., & Horne, R. (2004). Patients' problems with new medication for chronic conditions. Quality and safety in Health Care, 13(3),
9. BeLue, R., Okoror, T.A., Iwelunmor, J., Taylor, K.D., Degboe, A.N., Agyemang, C., et al. (2009). An overview of cardiovascular risk factor burden in sub-Saharan African countries: a socio-cultural perspective. Globalization and Health, 5(10).
10. Bernhardt, J. M. (2004). Communication at the core of effective public health. American Journal of Public Health, 94 (12),
11. Berry, D. (2007). Health Communication: Theory and Practice. Berkshire, England: Open University Press. 184
12. Bertakis, K.D., Franks, P., & Epstein, R.M. (2009). Patient-centered communication in primary care: physician and patient gender and gender concordance. Journal of Women‟s Health (Larchmt), 18(4),
13. Bharucha, A.J., Pandav, R., Shen, C., Dodge, H.H., & Ganguli, M. (2004). Predictors of nursing facility admission: a 12 year epidemiologic study in the United States. Journal of the American Geriatrics Society, 52(3),.
14. Bodin, T., Albin, M., Ardo, J., Stroh, E., Ostergren, P., & Bjork, J. (2009). Road traffic noise and hypertension: results from a cross-sectional public health survey in southern Sweden. Environmental Health, 8, 38.
15. Bredart, A., Bloulec, C., & Dolbeault, S. (2005). Doctor-patient communication

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com

and satisfaction with care in oncology. Current Opinion in Oncology, 17(14),

16. C., Lockyear, J., Laidlaw, T., & Macleod, H. (2007). Assessment of a matched-pair instrument to examine doctor-patient communication skills in practising doctors. Medical Education, 41(2),

Premlata Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: premshilaku08@gmail.com