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The Changing Patient-Provider Relationship: Charting the Future of Health Care

THE DOCTOR-PATIENT RELATIONSHIP AND COUNSELING FOR PREVENTIVE CARE

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SUMMARY

Theories and research related to the doctor-patient relationship have developed in a context of therapeutic care. This context is an increasingly inadequate definition of the boundaries of the doctor-patient relationship, as expectations grow for the physician's role in counseling for disease prevention and health promotion. This paper reviews the literature of the doctor-patient relationship, and extends its application to this newer context. Suggestions are discussed for overcoming some of the obstacles to the successful incorporation of counseling for preventive care in daily medical practice. Doctors and patients will benefit from a clarified understanding of their counseling responsibilities in disease prevention and health promotion as the theoretical and practical complexities of providing *health* care in *medical* institutions are examined.

Key words: Doctor-patient relationship — Prevention — Medical practice — Medical sociology

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Most health professionals would agree that 'an ounce of prevention is worth a pound of cure'. There now exists a list of accomplishments sufficiently long that few would dispute claims to success in the areas of primary prevention (e.g. seat belt use, childhood poisoning and dental caries), secondary prevention (e.g. cervical cancer mortality, congenital metabolic disorders), and combinations of the two (e.g. heart disease prevention, hypertension-induced diseases) [1].

Preventive medicine (including health promotion) is seen by many as a partial answer to the problem of health care costs, featuring a unique ability to blend both long- and short-term savings [2]. It is often asserted that physician teaching of health-promoting behaviors during the office visit will result in improved patient knowledge, satisfaction, and compliance [3], and that there has been a shift in medical care from curative to preventive types of services [4]. But, if this shift has indeed occurred, theories of the doctor-patient relationship have not kept pace. What lessons can be brought to bear from theory and research to help explain the nature of the physician-patient relationship in the context of prevention/health promotion in medical care?

BARRIERS TO A 'PREVENTION' APPROACH

A number of barriers exist to the incorporation of preventive care and health promotion in medical care settings, including: (a) lack of attention to prevention in medical education, both in formal education and in 'on-the-job' experience [5—9]; (b) lack of reimbursement for provision of preventive services and/or counseling for health promotion by the present financial structure (i.e. lack of 'third party' reimbursement) [6,7,10,11]; (c) lack of gratification and satisfaction for the physician, who is accustomed to obtaining more immediate results [6—9]; (d) lack of understanding of the unit of intervention by physicians, who are trained to understand medical care on an individual rather than on a population basis [10,12]; (e) perceived lack of time, space, and staff to provide preventive care [6,8]; (f) uncertainty about the medical evidence underlying preventive care, including inconsistent recommendations from professional groups and lack of cost-effectiveness data, absence of a historical basis, and the number of false positives in screening tests [6,8,9,11]; (g) need to coordinate with community resources [6]; (h) the comfort of the traditional 'disease model' of medical care, or 'custom' [7,11]; (i) a 'negative' set of attitudes and perceptions on the part of physicians, including the views that: (1) prevention is an inappropriate job role for a physician [6,7]; (2) prevention is a 'welfare' approach to medical care [9]; and (3) patients are likely to be non-compliant with (and hostile to) preventive recommendations [6,10,13]; and (j) physicians are not effective at providing this type of service [13—15].

Vicious cycle

A vicious cycle emerges, wherein the relationship itself becomes both enabler and barrier to the inclusion of preventive care. Inui and colleagues [13] have described the process of developing and implementing a systematic approach to preventive care; addressing primary as well as secondary prevention (i.e. health promotion as well as disease prevention), they are mindful of the effects of the doctor-patient relationship in this process:

> An *a priori* case can be made for attempting to affect attitudes and expectations of both parties involved [physicians and patients]. When attempting to implement indicated screening and counseling activities, for instance, a well-intentioned physician facing an unprepared patient may be met with a lack of understanding of the 'relevance' of his/her screening actions . . . a reluctance on the patient's part . . . and a significant resistance to suggestions for behavioral or other change . . . An 'activated' and well-informed patient who attempts to elicit preventive care . . . from an unprepared physician could also be met with reluctance and resistance, or could even seriously disturb the quality of the doctor-patient relationship.

Costs to the relationship can be high, and even the anticipation of such costs can interfere with the process. To the physician, costs of prevention include: patients who are uninterested in, and non-compliant with, lifestyle changes; assumption of responsibility for followup tests that are false positives; subjecting patients to inconvenience and procedures that may be deleterious without firm knowledge of the presence of disease; and potentially labelling a well person as ill [6]. For the patient, participation also has associated costs, including unexpectedly being labelled ill (with attendant anxiety); uncertainty about the efficacy of preventive care versus 'chance' alone; psychological costs associated with 'admitting' vulnerability to serious disease while asymptomatic; and a range of practical costs, such as time, inconvenience, and pain [6]. Actual financial costs must also be considered. Both physician and patient are under some constraints to control the financial expense associated with preventive care.

The issue of physicians' lack of perceived efficacy is an important one in understanding the dynamics of the physician-patient relationship in preventive care. Effective preventive measures call for a combination of three types of skills; judgmental, technical, and interpersonal. While these are potentially applicable to all aspects of medicine, interpersonal skills clearly come to the fore when trying to motivate patients to modify patterns of behavior, an important determinant of the success of a preventive intervention. Physicians feel that they lack effectiveness in this important aspect of preventive care — which then results in decreased patient acceptance of the recommendation [14].

A problematic cycle of attitudes and barriers thus emerges. In order to increase physicians' perceptions of efficacy, they will need to receive feedback on positive outcomes. This is not a task that current medical records and organizational structure are set up to accomplish over the relatively long-term period which is required to see positive change in health behavior. Furthermore, physicians cannot accurately predict outcomes in the absence of such concrete feedback [16].

The stage is therefore set for a conflict in physicians' attitudes, beliefs, and practices with regard to prevention. The term 'sociological ambivalence' [17,18] has been applied to define the mixed messages physicians receive about prevention, but it may be appropiately extended to characterize physicians, patients, and the models that have been established to aid in understanding the physician-patient relationship.

AMBIVALENT PERCEPTIONS OF PREVENTION

The prevention paradox

The promotion of health is a concept and an activity somewhat foreign to most physicians' habits of thought and action [19]. Distinctions between prevention and medical care are often made, and by virtue of this distinction a sense of conflict emerges. In 1984, Roemer [20] wrote to defend 'medical care' against what he termed its 'denigration' due to the rediscovery of the value of prevention in the 1970s. He argued that prevention and medical care reinforce each other, and therefore division between the two is wholly unsound, '. . . the recent tendency to counterpose prevention to medical care, heralding the value of health promotion while denigrating the wastefulness of treatment, creates a false dichotomy'. Mindful of the clamor for them to take an active role in prevention, physicians are being asked not only to integrate into their practice something which is unfamiliar and uncomfortable, but which is even seen as the 'enemy' of their central role: the provision of curative services.

In a study of public and physician attitudes toward the delegation of medical tasks to non-physician health workers, Breslau and Novack [21] discovered an interesting paradox in opinions regarding preventive services. Physicians' responses paralleled those of the lay public regarding most tasks — but with respect to regular checkups on babies and prenatal checkups, 'markedly higher proportions of the physicians than the public were willing to delegate to nonphysicians.' The investigators interpret this as a reflection of concern about maternal and infant health on the part of the public which is not shared by physicians. Conversely, physicians may perceive some obstacle to their provision of prenatal and pediatric preventive care of which the public is not aware (or does not share), including lack of skills or interest on the part of the physician. Well-baby checkups are most likely to fail to yield any intellectually stimulating findings. Of the 18 tasks given, the two prevention-oriented tasks were the only ones to experience this discrepancy in reaction.

Discrepancies are also evident between physicians' attitudes and their practice behavior. Physicians agree with published guidelines on inoculation programs, but fail to follow these guidelines in their practices [22]. Fewer than half of those patients for whom general physical exams and flu vaccinations are appropriate actually receive them, and just over half receive appropriate breast examinations (by a physician) or pap smears [13]. On the other hand, physicians have incorporated health promotion principles

in their own lives to a great extent, again suggesting some form of internal conflict or ambivalence. Labelling it a paradox, Dismuke and Miller [23] contrast physicians' own health behavior improvements with the lack of emphasis on such matters in their practices: 'Physicians have discovered some secrets to better health, but are reluctant or ineffective in communicating them to their patients.' Physicians have quit smoking at a rate higher than any other health-professional group. While in 1967, 30% of physicians were regular cigarette smokers, the proportion had declined to 21% by 1975 (i.e., 64% of all physicians in the U.S. who were smokers had quit in that 8-year period). Furthermore, in 1977, three-quarters of physicians agreed that a health professional should persuade people to stop smoking [24].

One proposed explanation for physicians' reluctance to incorporate preventive/health promoting services is the lack of agreement among experts as to what should be 'done' and how often. Pap smears are a good example of a preventive service which is not uniformly and consistently guided by experts; guidelines for frequency of performance of the pap smear for women over 40 years of age range from 'twice in five years', 'once in five years', at least every three years', to 'annually' [25]. On the subject of counseling for health promotion, most experts agree that it should be included, but there is 'little evidence that these activities are adequately performed, effective, or evident in office practice' [25]. There is something of a double standard for evaluating scientific evidence; commending physicians for some healthy skepticism about all aspects of prevention, Dismuke and Miller [23] contrast this with 'medicine's proclivity to accept technological and therapeutic changes. Physicians seem extremely willing to try a new chemical or surgical therapy on the basis of preliminary evidence of its efficacy.'

Perceived efficacy

Physicians' self-perceptions of ineffectiveness may help to account for this double standard and for the broader ambivalence toward prevention and health promotion found in medical practice [26,27]. A recent review by McClellan concluded that physician attitudes specifically toward patient education are positive, yet physicians experience insecurity with actual educational interventions [28].

In a survey of 433 primary care physicians, Wechsler [29] measured beliefs about health promotion, involvement in and support for health promotion activities, confidence in dealing with behavior change, and optimism about the chances of achieving success (i.e. perceived efficacy). Beliefs about the importance of health promotion activities 'for the average person' included 93% of the physicians stating that elimination of cigarette smoking was 'very important', and more than half replied similarly for seat belt use and for a balanced diet; however, fewer than half of these physicians felt that moderating or eliminating alcohol use, decreasing salt consumption, avoiding saturated fats, engaging in regular aerobic exercise, avoiding cholesterol, or minimizing sugar intake was 'very important'. Most of the physicians reported routinely asking patients about important health behaviors, and most (74%)

were of the opinion that it was 'definitely a physicians's responsibility to educate patients about each of these risk factors'. However, less than half of the physicians said they routinely ask about diet, exercise, or stress, and thus could not be expected to adequately fulfill this responsibility since they would not know which patients were at risk.

Of greater importance, both to the understanding of the ambivalence of physicians toward prevention and to the potential impact of this ambivalence on the physician-patient relationship, is the question of perceived efficacy. Wechsler asked these physicians how prepared they felt to deal with behavior change in six areas, how successful they thought they were, and how successful they thought they could be, given appropriate support. No more than 7% expressed confidence that they were 'very successful' in modifying any of six health-related behaviors (smoking, alcohol use, exercise, diet, drug use and stress), and no more than one out of five physicians expressed confidence that they could be very successful even under the best circumstances.

This theme of lack of perceived efficacy — even when administrative and other barriers are removed — is relevant to an understanding of physicians' attitudes about prevention, and therefore, to the physician-patient relationship in the context of preventive care. While physicians indicate that they are convinced of the importance of positive health practices, they also see themselves as being only minimally successful in helping their patients to modify these practices.

Second epidemiological revolution

Despite the experience of barriers to prevention and a lack of perceived efficacy on the part of physicians, the provision of just these types of services is called for by those both inside and outside the profession. Termed the 'second epidemiological revolution', the shift to preventive services and health promotion cannot be ignored. The American Medical Association (AMA) has called for increased attention to prevention and health promotion by clinicians, and, while a 1983 report does not emphasize physician counseling of patients for health promotion, it implies that it is this aspect of preventive care which could be most beneficial *to the doctor-patient relationship:*

> One of the greatest benefits of the patient's periodic visits to the physician is that both patient and physician have the opportunity to build the mutual trust and knowledge that will stand them in good stead, not only when acute illness may require the physician's care, but also when the physician attempts to foster those behaviors and activities that contribute to the prolonging of the patient's healthful and productive life. [30]

This reasoning creates a clear paradox for physicians. Frustration with non-compliance is part of their 'reason' for not conducting counseling for health promotion, yet this is the very dimension that the AMA argues will benefit *if* preventive care is incorporated. Going a step further, the AMA recommends that physicians improve their skills and practice in this area:

'physicians need to improve their abilities to instruct their patients about healthful living, the proper functioning of mind and body, and how to achieve them' [30]. Additional pressure has come from recent characterizations of the provision of health-promotive services as a 'survival' tactic for the medical profession. 'Unless group practices begin to see themselves as being in the *health business*, and not limited to the *medical care business*, they may find themselves in a much less predominant position in the future' [31].

Each of these pieces of evidence points toward an increasingly confused physician (and therefore patient) with regard to prevention and health promotion in medical practice. What should physicians expect from themselves in light of the expectations of others? What should patients realistically expect from their physicians? And what is the effect of this confusion on the physician-patient relationship when patients seek, or physicians initiate, preventive care?

TOWARD AN APPLICATION OF THEORY: ROLE CONFLICT AND ROLE AMBIGUITY

Recent media emphasis on what the public should be doing to be healthier has served to illuminate what people are not doing — i.e., to further enhance the perception of what Zola has termed the 'omnipresence of disorder' [32]. Since disorders are, by definition, under control of the medical institution, then this lay self-improvement movement has expanded the domain of medicine. The profession, and individual physicians, may be ill-equipped to deal with this new challenge, both in terms of quantity of time and quality of skill.

Theories of role ambiguity and role conflict can be applied to assist in clarifying the difficulties of the physician-patient relationship in preventive care. 'Role conflict' is the degree of incongruity or incompatability of expectations associated with a role; 'role ambiguity' refers to the lack of clarity of role expectations and the degree of uncertainty regarding the outcomes of one's role performance [33]. Role ambiguity may be more pervasive than role conflict in its effects on personal outcomes, but role conflict demands organizational intervention if it is to be prevented or resolved. Each is, in a sense, subjectively experienced, so that the same amount of ambiguity might be seen by one work group as 'satisfying autonomy', and by another group as 'a dissatisfying lack of role clarity' [34]. Furthermore, role strains stem not from the unavailability of suitable roles but from problems of choice and adjustment [35]. Role conflict, role ambiguity, and role strain are each operative in the physician-patient relationship in the context of preventive care.

Two types of role conflict

We have noted that physicians experience ambivalence toward prevention as a result of both their own expectations (which they do not generally feel

they are able to meet) and the expectations of their profession (contrasted with the costs and scarcity of rewards of prevention). Two types of role conflict are evident here: interrole conflict, which occurs between multiple roles or offices held by the same person (e.g. physician as high-technology treatment source vs. physician as teacher), and person-role conflict, which occurs between the focal person's own role expectations and those applied to him by a significant other (e.g. physicians who perceive themselves as referral sources for health promotion counseling vs. patients who perceive physicians as their source of preventive care and counseling) [36]. In one sense, person-role conflict is a subtype of interrole conflict wherein the focal person serves as one of the role senders.

These theories can be appropriately applied to physicians and patients in preventive care, in light of the conflicts previously discussed. In addition, as the demands posed by self-expectations increase, perceived role ambiguity increases: 'Many of the correlates we associate with role disagreement, or conflict, are attributable to one's self expectations and the perceptions of others' expectations [36]. Considering the lack of perceived self-efficacy on the part of physicians, a relationship emerges between that psychosocial dilemma and the experiences of role ambiguity and conflict.

Parsons [37] has argued for social control of the physician-patient roles, recognizing the potential for strain on both sides of the physician-patient relationship. Speaking to the issue of ambivalence, he noted that this type of ambivalence and/or conflict is likely to 'break through into hostile acts'. Therefore, should one or the other party to the physician-patient relationship experience this type of role conflict, it is likely to affect the relationship itself. In Parson's view, this situation is particularly probable when the physician has a strong emotional interest in success and an inevitable involvement in psychologically significant 'private' affairs of patients. It can be argued that both of these criteria apply to the physician-patient relationship in the context of preventive care, when the physician may already be feeling inadequate and the topic of discussion is a personal health behavior which represents psychological needs or defenses to the patient (e.g. overeating, smoking, alcohol abuse etc.).

Although Parsons was not specifically addressing preventive care, his notion of 'functional specificity' helps to outline the process by which this role conflict can emerge: 'Specificity of the scope of concern . . . has the function of defining the relationship to patients so that it can be regulated in certain ways and certain potential alternatives of definition, which might be disruptive, can be excluded or controlled [37]. One may consider the incorporation of prevention and health promotion in medical care as an alternative and disruptive definition of the scope of the physician's role.

The physician-patient relationship in preventive care is fraught with opportunities for both parties to experience role ambiguity and/or role conflict. The fact that physicians often do not recognize behavioral, psychological, and social aspects of their patients' problems is contrasted with the need patients have for discussion of these issues in order to comply with the

regimen and to experience satisfaction with their medical care [3,16,38–46]. A conflict is evident: the physician is supposed to address particular issues in a particular way, but frequently cannot (for whatever reason) recognize their existence.

Need for a different physician-patient relationship

Preventive services require a different model of the physician-patient relationship than do therapeutic services. Szasz and Hollender [47], in their early work on the physician-patient relationship, noted that 'problems in human contact between physician and patient often arise if in the course of treatment changes require an alteration in the pattern of the doctor-patient relationship'. We will return to this point in a subsequent discussion of models of the physician-patient relationship applied to preventive care — but the point to be noted here is that examination of the expectations of the physician and the patient in preventive care, and the role ambiguity and conflict associated with them, has practical implications for physicians and patients as they relate to each other in the clinical setting.

The physician's role

Based on attitudinal data obtained by mail questionnaire and behavioral data collected through tape recordings of the doctor-patient interaction over successive clinic visits, Davis [48] concluded that 'the degree to which a doctor fulfills the idealized conception of his role varies from time to time'.

The fulfillment of roles by physicians and patients is not necessarily consistent or isolated. The patient role too must be placed in the context of organizational processes, and a distinction should be made between expectations resulting from structural aspects of a 'status' and expectations which are attached to the function ascribed to a role. The function and structure issue will not be resolved here, but it is important to know that these expectations, which may result in conflict and thereby hinder the physician-patient relationship, may stem from one or both of these sources.

Sources of role strain

Sources of role strain for the physician and the patient are expectations ascribed to them, both externally and internally. As an example, Berg [49] lists reasons why patient education and preventive medicine create disappointment and negative reactions; one reason is that this type of care is 'no fun for the physician — there is no warm physician-patient relationship, no adoration or reverence offered the physician. Whether this is true or not, the perceived equivalence of a warm (or successful) physician-patient relationship with an adored and revered physician is likely to set up expectations for physicians and patients which cannot be consistently met. As Berg notes, the physician-patient relationship in patient education and preventive medicine involves 'a much broader understanding of where the patient is at, what his internal resources are, and how a genuine partnership between doctor and patient will be achieved'.

As a further source of role ambiguity, the concepts of maintenance of distance and control of affect by the physician are potentially even more confusing in prevention than in therapeutic care. Producing role strain for physicians, a 'subtle balance is required . . . While patients expect doctors to be sympathetic and to show some affect, the physician is professionally bound to maintain an appropriate distance, to be controlled emotionally, and to be nonpartisan' [38]. Physicians attempt a stance of neutrality toward all their patients (as reflected in their report that they give the same amount of attention to all patients), but this is especially problematic in the context of health promotion, where some patients will require much more attention than others, if only because of differential presence and severity of risk factors.

An additional contribution to role ambiguity and conflict is a self/other selection process by which physicians are at particularly high risk of experiencing role ambiguity and its repercussions. Need for independence and need for achievement have been found to moderate relationships between role variables and satisfaction; high need-for-achievement subjects have a more negative relationship between task ambiguity and satisfaction [50]. The system of selection into medical schools and the nature of medical training ensures that physicians are relatively more likely to fall into this high need-for-achievement category.

Experience of role ambiguity and conflict is directly related to job tension, dissatisfaction, and futility; inversely related to self-confidence; and causes lower levels of job satisfaction and unfavorable attitudes toward role-senders [33,36]. In light of physicians' expressed concerns about the future of medical care (job tension, dissatisfaction) and their perceptions of lack of efficacy in prevention/health promotion (futility, lack of self-confidence), it may be that patients are seen as the role-senders in prevention.

If this is the case, negative effects on the physician-patient relationship are inevitable. Patients too are hypothesized to have difficulty with their role in the physician-patient relationship relative to prevention/health promotion. They may feel most threatened because their daily habits and lifestyles are at issue, and because responsibility for disease outcomes is ascribed to them personally. For example, Korsch and colleagues [44] found that mothers of pediatric patients felt particularly vulnerable during preventive visits, and felt that their competence was being judged and appraised most critically by the doctors in this context.

Writing to encourage the practice of preventive medicine and health promotion, Relman defines the appropriate roles for physicians (and therefore for patients) in preventive care [7]:

> [An] obligation of the medical profession is to attempt to persuade patients to adopt those strategies that have been proven effective. Physicians must be careful, however, to avoid officiousness and they must not intrude on the freedom of patients to choose their own lifestyle once the facts and consequences are clearly understood. Physicians should be teachers and counselors, not supervisors, policemen, surrogate parents, or bureaucrats.

Clearly, this calls for the making of fine distinctions, by physicians and patients. Where does teacher end and 'supervisor' begin? What if the physician has only acted as 'supervisor' with his patient because that was the most effective role for therapeutic care?

APPLICATION OF MODELS

Lack of appropriate definitions

The narrow assumptions underlying most analyses of the physician-patient relationship focus on a two-person interaction, or dyad. Acute illness best fits this dyadic model, but prevention requires that attention be paid to patient populations; where does the 'patient-practitioner dyad' fit in this context? [51].

It can be argued that physician resistance (as a profession) to prevention has historically stemmed from a requisite shift in the balance of power in the physician-patient relationship required by the context of prevention. Preventive care, and the relationship contained in it, violates virtually all sociological assumptions about the relationship, and about the definition of the professional. In preventive medical care and health promotion, patients are not deviant (at least in the sense of not being able to fulfill their responsibilities to society), and the knowledge gap between physician and patient may be substantially narrowed [18].

Gordon [52] challenges the assertion that the relationship between illness and dependence is continuous; on the basis of a survey of New York City residents, he concluded that there are two distinct and unrelated sets of behavioral expectations relevant to the ill person: the sick role, when prognosis is serious and uncertain; and the impaired role, when health is impaired but the prognosis appears not to be serious. These two roles were found to be associated with differential expectations about dependence, and can be extrapolated to the physician-patient relationship.

This points to precisely the reason that the nature of dependence and authority in the physician-patient relationship (as suggested in the literature) cannot be applied to preventive care; it is based on the sick role (or a variation of it) that implies an impairment of social functioning. Nor can an impaired role be applied to the patient in preventive care, since such a role implies 'that there is recognition of the impairment . . . and that extra effort is involved if the impaired person is to be independent' [52].

Applying the literature on physician-patient communication to the preventive interaction is, at best, an effort at extending and reshaping the implications of this literature, since studies of communication have traditionally dealt with 'acute, often short-term, sometimes self-limited illnesses' [41]. Physicians have the 'conceptual tendency to isolate the person and his or her social life from the body' [53], but in effective prevention/health promotion that approach is unworkable.

Even among those who aim to teach physicians how to practice 'humanistic

medicine', the medical model is very much in evidence, operating within assumptions of authority and control set in a therapeutic context, as when patients are described as 'types of patients that are likely to produce counter-productive behavior in health care professionals' [53]. The structure of preventive care and its implications for the physician-patient relationship on a 'micro' level can thus not be based in the literature on physician-patient interaction.

On a more 'macro' level, several characteristics of preventive care and of the models of the physician-patient relationship mitigate against the two being merged. Reeder characterizes curative care as a 'seller's market', and prevention as a 'buyer's market' [4] Besides the obvious problems of switching types of markets (and expecting to apply the same models and principles to each) is the added complication that the physician-patient relationship in preventive care (buyer's market) takes place in the context of continuity of care built on provision of therapeutic services (seller's market). The overall relationship, then, becomes a 'mix of markets' wherein neither party is comfortably the 'seller' or the 'buyer' at any particular visit.

The basic models

The classic literature of the physician-patient relationship is founded on an assumption of therapeutic care; as Szasz and Hollender [47] note, 'certain philosophical preconceptions associated with notions of 'disease,' 'treatment,' and 'cure' have a profound bearing on both the theory and practice of medicine'. Prevention cannot fit neatly into any of Szasz and Hollender's three models of the physician-patient relationship; while it is closest to their 'mutual participation model', this model requires that (1) the participants have approximately equal power; (2) the participants are mutually interdependent; (3) the participants engage in activity that will be in some ways satisfying to both.

The satisfaction criterion may be lacking in application to preventive care, since (as noted earlier) physicians do not have the skill or access to organizational structure to facilitate obtaining satisfaction by providing preventive services, and it may be difficult for patients to find satisfaction in preventive care when positive results are based largely on the absence of disease events. Szasz and Hollender also place 'advice to smoke less' as an example of the 'guidance-cooperation model', but this model assumes unequal power (balanced toward the physician) which may be contrary to the reality of power in a relationship where the knowledge gap is considerably narrowed, and where the physician may not have skills requisite to assisting the client in undertaking the relevant behavior.

The sick role

Parsons' [37] sick role concept underlies much of the literature on the physician-patient relationship; but, as Field [54] argues, preventive care 'does not fall into the traditional characterization of medicine's role as society's repair shop for dysfunctional components'. The sick role approach

is inapplicable because of the nature of the 'condition' itself, and also because attendant assumptions about helplessness, professional referral, and emotional involvement do not apply [55]. 'Unlike the sick role, prevention imposes substantial responsibilities on an individual either to avoid illness or to prevent complications associated with illness, but, at the same time, it confers few societal privileges for taking such action' [6]. Physician and patient roles are changed in prevention, since many of the recommended changes in lifestyle require at least the patient's voluntary cooperation and assumption of responsibility. Thus, successful implementation of preventive care programs may necessitate a 'more active . . . role [for the patient] in decision-making with the physician assisting the patient to help him/herself [6].

Power and authority

Freidson [56] asserts that the further the client penetrates the professional referral system, the more control rests in the hands of the practitioner. In the case of preventive services, primary care is the usual milieu. Therefore, if the converse of Freidson's assertion is also true, the patient has the greatest absolute control in the preventive interaction. On the other hand, the medical profession has first claim to jurisdiction over the label 'illness' and, as Zola [32] points out, 'anything to which it may be attached, irrespective of its capacity to deal with it effectively'. Zola characterizes this process in four ways: (a) the expansion of what in life is deemed relevant to the good practice of medicine; (b) the retention of absolute control over certain technical procedures; (c) the retention of near absolute access to certain 'taboo' areas; (d) the expansion of what in medicine is deemed relevant to the good practice of life.

The last criterion could focus specifically on preventive care and health promotion. By definition, modification of health behavior means deciding what is 'the good practice of life'. In prevention, therefore, the 'expansion

	POWER TO DEFINE PROBLEMS	POWER TO CORRECT PROBLEMS
Therapeutic care	Physician and Patient (symptom recognition)	Physician
Preventive medicine, screening	Physician	Physician and Patient
Health promotion, risk reduction	Physician and Patient	Patient

Fig. 1. Power to define and correct problems. A model.

into life' becomes even deeper, since the very idea of primary prevention means getting there *before* the disease process starts. One might thus conclude that the physician's role in prevention is one of even greater authority than that implied in the literature on the physician-patient relationship in therapeutic care.

An additional paradox is possible conflict between models of the physician-patient relationship in preventive medical care and the relationship in health promotion. By adhering to a systematic schedule of periodic exams, the patient has identified the physician as the individual with the knowledge and power to define the problem; yet, by seeking and/or responding to advice to improve health behavior, the patient is accepting responsibility for action to correct the problem. If power is dichotomized as 'power to define problems' and 'power to correct problems', then different schema are operationalized in preventive medicine as compared with health promotion, as depicted in Fig. 1.

This model is related to one offered by Brickman et al. [57] that considers responsibility for the cause of a problem and responsibility for its solution. By addressing responsibility for the *definition* of problems, this model reveals that Brickman's 'medical model' is indeed composed of at least four schema which have different authority structures and different assignments of responsibility. We must still address the complication of physicians and patients relating to each other in a continuing capacity, wherein the type of care (and therefore the model of the relationship) is alternating.

Persuasion and authority

The nature of the development of communication between two parties assumes that each communicator begins to infer or predict behavior in the other communicator on the basis of the other's past behaviors, and that each communicator then infers the reasons why the other communicator behaves in certain ways [58]. Dyadic communication is thus based on a growth and development perspective, which in turn implies a sustained relationship. Prevention and health promotion occur in the context of a continuing physician-patient relationship which also circumscribes interactions based on acute and/or chronic medical needs. Thus, clear distinctions about the nature of the physician-patient relationship in various types of care are difficult to maintain in the context of daily medical practice.

Starr [59] notes that *persuasion* works through a process of argumentation, and notes that that when persuasion is used, authority is 'left in abeyance'. But if the process of persuasion is inconsistent with the exercise of authority, and if persuasion is necessarily part of patient education for health promotion, then authority cannot be a component of the physician-patient relationship relative to health promotion. Instead, even this process of persuasion, if built in a context of an otherwise authority-based relationship, is also founded in authority and perceptions of power imbalances. As Starr observes, 'authority relations are not fixed and untroubled. Often they go through periods of distress. In such periods, the legitimacy of authority

may be in doubt, but the ongoing dependence of subordinates maintains authority' [59].

SUMMARY MODEL AND SUGGESTIONS FOR IMPROVEMENT

The inapplicability of many of the theoretical constructs outlined above suggests that we must alter our understanding of the nature of the doctor-patient relationship in preventive care. Furthermore, structural changes are necessary in the practice of medicine if preventive counseling is to have satisfactory outcomes. A model of the antecedents to unsatisfactory outcomes in preventive care is presented in Fig. 2.

Intervention directed at any of the four antecedents in this problematic cycle could help to reduce negative outcomes and to increase the likelihood that the physician-patient relationship in the context of preventive care will be rewarding to both parties. No intervention, either singly or in combination, is likely to eliminate these problems; however, the following set of proposed actions should enable the patient and physician to gain greater satisfaction from the relationship.

I. Patient expectations for 'treatment' from physician

(a) Improve physicians' communication skills, so that as a natural outgrowth of this process physicians can assist patients in understanding the appropriate expectations for medical screening and for risk factor intervention.

(b) Through physician direction and public health education, help patients to learn to voice expectations in a positive way, without hostility which may be counterproductive to the relationship and to health outcomes.

II. Physician expectations for authority and treatment success

(a) Through primary and continuing medical education, teach the 'population perspective' of medicine, using role-model physicians. Encourage appreciation of long-term results, and of what constitutes 'success' in preventive interventions [60].

(b) Build a feedback mechanism into the organizational context so that physicians will be aware of 'successes' on a case-by-case basis.

III. Patient lacks skills to accept necessary assignment of responsibility from physician

(a) Encourage knowledge of sound non-medical 'treatment' resources, including education, community, and family resources so that patients perceive responsibilities as less overwhelming and more achievable.

(b) Provide skills education for behavior change through media, including less attention to gimmicks and greater attention to techniques such as

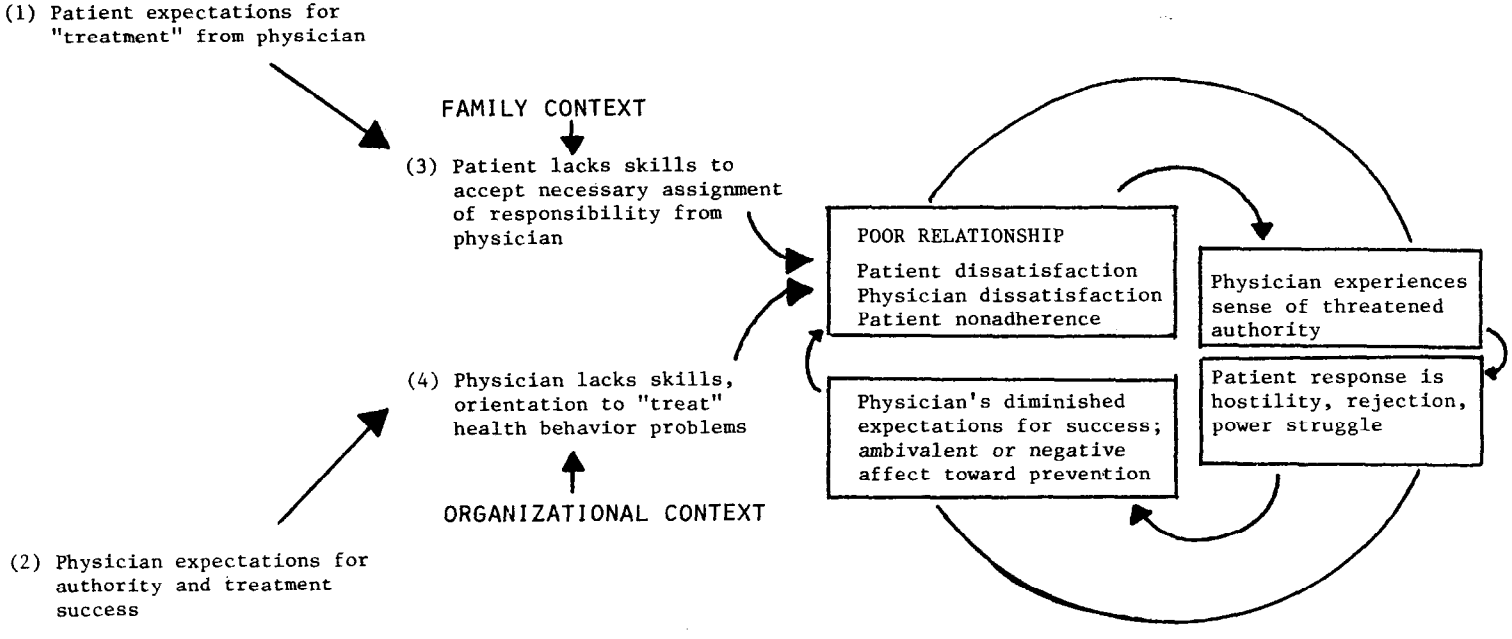

Fig. 2. Model of the antecedents to unsatisfactory outcomes in preventive care.

behavior modification, depicted in the context of a working relationship with the physician.

IV. Physician lacks skills and orientation to 'treat' health behavior problems

Improve physician skills in: information transfer and communication [44,45]; awareness of other resources and referral skill [60—62]; followup of risk factors detected [61]; acting as a role model [61,63], and organizational management to free time for patient counseling [60] through:

(a) Undergraduate and graduate medical education, and continuing medical education [45,60,63—67].

(b) Improved insurance coverage and reimbursement for preventive services [7,60].

(c) Changes in the organizational context, including encounter forms for the visit which remind the physician of preventive procedures and patient education to be conducted, and medical record systems which record the 'qualitative' as well as 'quantitative' outcomes of visits [26,68].

A clarified understanding

In light of the previous discussion concerning the inapplicability of extant models of the physician-patient relationship to the context of preventive care, it is likely that many of these suggestions would meet with resistance and be difficult to effect. However, as we begin to bring to bear the lesions from traditional theories of the doctor-patient relationship, and to tackle the theoretical and practical complexities of providing *health* care in *medical* institutions, a better understanding of solutions will emerge. Doctors and patients will benefit from a clarified understanding of their counseling responsibilities in disease prevention and health promotion.

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