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METAPHORS AND MODELS OF DOCTOR-PATIENT RELATIONSHIPS: THEIR IMPLICATIONS FOR AUTONOMY

INTRODUCTION

Many metaphors and models have been applied to relationships between patients and physicians. One example is an interpretation of physician-patient relationships as paternalistic. In this case, the physician is regarded as a parent and the patient is regarded as a child. Opponents of such a paternalistic view of medicine rarely reject the use of metaphors to interpret medical relationships; rather, they simply offer alternative metaphors, for example, the physician as partner or the patient as rational contractor. Metaphors may operate even when patients and physicians are unaware of them. Physician-patient conflicts may arise if each party brings to their encounter a different image of medicine, as, for example, when the physician regards a paternalistic model of medicine as appropriate, but the patient prefers a contractual model.

As these examples suggest, metaphors involve seeing something as something else, for example, seeing a lover as a red rose, human beings as wolves, or medical therapy as warfare. Metaphors highlight same features and hide other features of their principal subject[1]. Thus, thinking about a physician as a parent highlights the physician's care for dependent others and his or her control over them, but it conceals the patient's payment of fees to the physician. Metaphors and models may be used to describe relationships as they exist, or to indicate what those relationships ought to be. In either the descriptive or the prescriptive use of metaphors, this highlighting and hiding occurs, and it must be considered in determining the adequacy of various metaphors. When metaphors are used to describe roles, they can be criticized if they distort more features than they illuminate. And when they are used to direct roles, they can be criticized if they highlight one moral consideration, such as care, while neglecting others, such as autonomy.

Since there is no single physician-patient relationship, it is probable that no single metaphor can adequately describe or direct the whole range of relationships in health care, such as open heart surgery, clinical research, and psychoanalysis. Some of the most important metaphors that have shaped health care in recent years include: parent-child, partners, rational contractors, friends, and technician-client. We want to determine the adequacy of these metaphors to describe and to direct doctor-patient relationships in the real world. In particular, we will assess them in relation to patient and physician autonomy.

METAPHORS AND MODELS OF RELATIONSHIPS IN HEALTH CARE

(1) The first metaphor is ***paternal*** **or** ***parental,*** and the model is paternalism. For this model, the locus of decision-making is the health care professional, particularly the physician, who has 'moral authority' within an asymmetrical and hierarchical relationship. (A variation on these themes appear in a model that was especially significant earlier – the priest-penitent relationship.)

Following Thomas Szasz and Marc Hollender, we can distinguish two different versions of paternalism, based on two different prototypes[2]. If we take the ***parent-infant relationship*** as the prototype, the physician's role is active. while the patient's role is passive. The patient, like the infant, is primarily a dependent recipient of care. This model is applied easily to such clinical situations as anesthesia and to the care of patients with acute trauma, coma, or

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delirium. A second version takes the ***parent-adolescent child*** relationship as the prototype. Within this version, the physician guides the patient by telling him or her what to expect and what to do, and the patient co-operates to the extent of obeying. This model applies to such clinical situations as the outpatient treatment of acute infectious diseases. The physician instructs the patient on a course of treatment (such as antibiotics and rest), but the patient can either obey or refuse to comply.

The paternalist model assigns moral authority and discretion to the physician because good health is assumed to be a value shared by the patient and the physician and because the physician's competence, skills, and ability place him or her in a position to help the patient regain good health. Even if it was once the dominant model in health care and even if many patients and physicians still prefer it, the paternalist model is no longer adequate to describe or to direct all relationships in health care. Too many changes have occurred. In a pluralistic society such as ours, the assumption that the physician and patient have common values about health may be mistaken. They may disagree about the *meaning* of health and disease (for example, when the physician insists that cigarette smoking is a disease, but the patient claims that it is merely a nasty habit) or about the *value* of health relative to other values (for example, when the physician wants to administer a blood transfusion to save the life of a Jehovah's Witness, but the patient rejects the blood in order to have a chance of heavenly salvation).

As a normative model, paternalism tends to concentrate on care rather than respect, patients' needs rather than their rights, and physicians’ discretion rather than patients' autonomy or self-determination. Even though paternalistic actions can sometimes be justified, for example, when a patient is not competent to make a decision and is at risk of harm, not all paternalistic actions can be justifled[3].

(2) A second model is one of ***partnership,*** which can be seen in Eric Cassell's statement: "Autonomy for the sick patient cannot exist outside of a good and properly functioning doctor-patient relation. And the relation between them is inherently a *partnership*"[4].The language of collegiality, collaboration, association, co-adventureship, and covenant is also used. This model stresses that health care professionals and their patients are partners or colleagues in the pursuit of the stared value of health. It is similar to the paternalist model in that it emphasizes the shared general values of the enterprise in which the participants are involved. But what makes this model distinctive and significant is its emphasis on the equality of the participants' interpretations of shared values such as health, along with respect for the personal autonomy of all the participants[5]. The theme of equality does not, however, cancel a division of competence and responsibility along functional lines within the relationship.

Szasz and Hollender suggest that the prototype of the model of 'mutual participation' or partnership is the adult-adult relationship. Within this model the physician helps the patient to help himself, while the patient uses expert help to realize his (and the physician's) ends. Some clinical applications of this model appear in the care of chronic diseases and psychoanalysis. It presupposes that "the participants (1) have approximately equal power, (2) be mutual1y interdependent (i.e., need each other), and (3) engage in activity that will be in some ways satisfying to both". Furthermore, "the physician does not know what is best for the patient. The search for this becomes the essence of the therapeutic interaction. The patient's own experiences furnish indispensable information for eventual agreement, under otherwise favorable circumstances, as to what 'health' might be for him"[6].

Although this model describes a few practices, it is most often offered as a normative model, indicating the morally desirable and even obligatory direction of practice and research[7]. As a normative model, it stresses the equality of value contributions and the autonomy of both professionals and other participants, whether sick persons or volunteers for research.

(3) A third model is that of ***rational contractors***. Health care professionals and their patients are related or should be related to each other by a series of specific contracts. The prototype of this model is the specific contract by which individuals agree to exchange goods and services, and the enforcement of such contracts by governmental sanctions. According to Robert Veatch, one of the strongest proponents of the contractual model in health care, this model is the best compromise between the *ideal of partnership,* with its emphasis on both equality and autonomy, and the *reality* of medical care, where mutual trust cannot be presupposed. If we could realize mutual trust, we could develop partnerships. In the light of a realistic assessment of our situation, however, we can only hope for contracts. The model of rational contracts, according to Veatch, is the only realistic way to share responsibility, to preserve both equality and autonomy under less than ideal circumstances, and to protect the integrity of various parties in health care (e.g., physicians are free not to enter contracts that would violate their consciences and to withdraw from them when they give proper notice) [8].

Such a model is valuable but problematic both descriptively and normatively. It neglects the fact that sick persons do not view health care needs as comparable to other wants and desires, that they do not have sufficient information to make rational contracts with the best providers of health services, and that current structure of medicine obstructs the free operation of the marketplace and of contracts[9]. This model may also neglect the virtues of benevolence, care, and compassion that are stressed in other models such as paternalism and friendship.

(4) A fourth attempt to understand and direct the relationships between health care professionals and patients stresses ***friendship***. According to P. Lain Entralgo,

> Insofar as man is a part of nature, and health an aspect of this nature and therefore a natural and objective good, the *medical relation* develops into comradeship, or association for the purpose of securing this good by technical means. Insofar as man is an individual and his illness a state affecting his personality, the medical relation ought to be more than more comradeship - in fact it should be a friendship. All dogma apart, a good doctor has always been a friend to his patient, to all his patients[10].

For this version of 'medical philia', the patient expresses trust and confidence in the physician while the doctor’s "friendship for the patient should consist above all in a desire to give effective technical help - benevolence conceived and released in technical terms"[11]. Technical help and generalized benevolence are 'made friendly' by explicit reference to the patient's personality.

Charles Fried's version of 'medical philia' holds that physicians are *limited, special-purpose friends* in relation to their patients. In medicine as well as in other professional activities such as law, the client may have a relationship with the professional that is analogous to friendship. In friendship and in those relationships, one person assumes the interests of another. Claims in both sets of relationships are intense and demanding, but medical friendship is more limited in scope [12].

Of course, this friendship analogy is somewhat strained, as Fried recognizes, because needs (real and felt) give rise to medical relationships, even if professionals are free not to meet them unless they are emergencies, because patients pay professionals for their 'personal care', and because patients do not have reciprocal loyalties. Nevertheless, Fried's analysis of the medical relationship highlights the equality, the autonomy, and the rights of both parties - the 'friend' and the 'befriended'. Because friendship, as Kant suggested, is "the union of two persons through equal and mutual love and respect", the model of friendship has some ingredients of both paternalism (love or care) and anti-paternalism (equality and respect) [13]. It applies especially well to the same medical relationships that fit partnership; indeed, medical

friendship is very close to medical partnership, except that the former stresses the intensity of the relationship, while the latter stresses the emotional reserve as well as the limited scope of the relationship.

(5) A fifth and final model views the health care professional as a ***technician***. Some commentators have referred to this model as plumber, others as engineer; for example, it has been suggested that with the rise of scientific medicine the physician was viewed as "the expert engineer of the body as a machine"[14]. Within this model, the physician 'provides' or 'delivers' technical service to patients who are 'consumers'. Exchange relations provide images for this interpretation of medical relations.

This model does not appear to be possible or even desirable. It is difficult to imagine that the health care professional as technician can simply present the 'facts' unadorned by values, in part because the major terms such as health and disease are not value-free and objective. Whether the 'technician' is in an organization or in direct relation to clients, he or she serves some values. Thus, this model may collapse into the contractual model or a **bureaucratic model** (which will not be discussed in this essay). The professional may be thought to have only technical authority, not moral authority. But he or she remains a moral agent and thus should choose to participate or not in terms of his or her own commitments, loyalties, and integrity. One shortcoming of the paternalist and priestly models, as Robert Veatch notes, is the patient's "moral abdication", while one shortcoming of the technician model is the physician's "moral abdication"[15]. The technician model offers autonomy to the patient, whose values dominate (at least in some settings) at the expense of the professional's moral agency and integrity. In other models such as contract, partnership, and friendship, moral responsibility is shared by all the parties in part because they are recognized, in some sense, as equals.

RELATIONS BETWEEN INTIMATES AND BETWEEN STRANGERS

The above models of relationships between physicians and patients move between two poles: intimates and strangers[16]. In relations of intimacy, all the parties know each other very well and often share values, or at least know which values they do not share. In such relations, formal rules and procedures, backed by sanctions, may not be necessary; they may even be detrimental to the relationships. In relations of intimacy, trust rather than control is dominant. Examples include relationships between parents and children and between friends. Partnerships also share some features of such relationships, but their intimacy and shared values may be limited to a specific set of activities.

By contrast, in relations among strangers, rules and procedures become very important, and control rather than trust is dominant[17]. Of course, in most relations there are mixtures of trust and control. Each is present to some degree. Nevertheless, it is proper to speak about relations between strangers as structured by rules and procedures because the parties do not know each other well enough to have mutual trust. Trust means confidence in and reliance upon the other to act in accord with moral principles and rules or at least in accord with his or her publicly manifested principles and rules, whatever they might be. But if the other is a stranger, we do not know whether he or she accepts what we would count as moral principles and rules. We do not know whether he or she is worthy of trust. In the absence of intimate knowledge, or of shared values, strangers resort to rules and procedures in order to establish some control. Contracts between strangers, for example, to supply certain goods, represent instances of attempted control. But contractual relations do not only depend on legal sanctions; they also

presuppose confidence in a shared structure of rules and procedures. As Talcott Parsons has noted, "transactions are actually entered into in accordance with a body of binding rules which are not part of the ad hoc agreement of the parties"[18].

Whether medicine is now only a series of encounters between strangers rather than intimates, medicine is increasingly regarded by patients and doctors, and by analysts of the profession -such as philosophers, lawyers, and sociologists- as a practice that is best understood and regulated as if it were a practice among strangers rather than among intimates. Numerous causes can be identified: First, the pluralistic nature of our society; second, the decline of close, intimate contact over time among professionals and patients and their families; third, the decline of contact with the 'whole person', who is now parceled out to various specialists; fourth, the growth of large, impersonal, bureaucratically structured institutions of care, in which there is discontinuity of care (the patient may not see the same professionals on subsequent visits) [19].

In this situation, Alasdair MacIntyre contends, the modern patient "usually approaches the physician as stranger to stranger: and the very proper fear and suspicion that we have of strangers extends equally properly, to our encounters with physicians. We do not and cannot know what to expect of them . . . "[20]. He suggests that one possible response to this situation is to develop a rule-based bureaucracy in which "we can confront *any* individual who fills a given role with exactly the same expectation of exactly the same outcomes . . .". Our encounters with physicians and other health care professionals are encounters between strangers precisely because of our pluralistic society: several value systems are in operation, and we do not know whether the physicians we encounter share our value systems. In such a situation, patient autonomy is "a solution of last resort" rather than "a central moral good". Finally patients have to decide for themselves what will be done to them or simply delegate such decisions to others, such as physicians.,

Just as MacIntyre recognizes the value of patient autonomy in our pluralistic society, so John Ladd recognizes the value of the concept of rights among strangers[21]. He notes that a legalistic, rights-based approach to medicine has several important advantages because rules and rights "serve to define our relationships with strangers as well as with people whom we know . . . In the medical context . . . we may find ourselves in a hospital bed in a strange place, with strange company, and confronted by a strange physician and staff. The strangeness of the situation makes the concept of rights, both legal and moral, a very useful tool for defining our relationship to those with whom we have to deal".

Rules and rights that can be enforced obviously serve as ways to control the conduct of others when we do not know them well enough to be able to trust them. But all of the models of health care relationships identified above depend on some degree of trust. It is too simplistic to suppose that contracts, which can be legally enforced, do away with trust totally. Indeed, as we have argued, a society based on contracts deepens to a very great extent on trust, precisely because not everything is enforceable at manageable cost. Thus, the issue is not simply whether trust or control is dominant, but, in part, the basis and extent of trust. Trust, at least limited trust, may be possible even among strangers. There may be a presumption of trust, unless the society is in turmoil. And there may be an intermediate notion of 'friendly strangers'. People may be strangers because of differences regarding values or uncertainty regarding the other's values; they may be friendly because they accept certain rules and procedures, which may ensure that different values are respected. If consensus exists in a pluralistic society, it is primarily about rules and procedures, some of which protect the autonomy of agents, their freedom to negotiate their own relationships.

PHYSICIAN-PATIENT INTERACTIONS AS NEGOTIATIONS

It is illuminating, both descriptively and prescriptively, to view some encounters and interactions between physicians and patients as negotiations. The metaphor of negotiation has its home in discussions to settle matters by mutual agreement of the concerned parties. While it frequently appears in disputes between management and labor and between nations, it does not necessarily presuppose a conflict of interests between the parties. The metaphor of negotiation may also illuminate processes of reaching agreement regarding the terms of continuing interaction even when the issue is mainly the determination of one party's interests and the means to realize those interests. This metaphor captures two important characteristics of medical relationships: **(1)** it accents the autonomy of both patient and physician, and **(2)** it suggests a process that occurs over time rather than an event which occurs at a particular moment.

The model of negotiation can both explain what frequently occurs and identify what ought to occur in physician-patient interactions. An example can make this point: A twenty eight year old ballet dancer suffered from moderately severe asthma. When she moved from New York to Chicago she changed physicians and placed herself in the hands of a famed asthma specialist. He initiated aggressive steroid therapy to control her asthma, and within several months he had managed to control her wheezing. But she was distressed because her dancing had deteriorated. She suspected that she was experiencing muscle weakness and fluid accumulation because of the steroid treatment. When she attempted to discuss her concerns with the physician, he maintained that "bringing the disease under complete control -achieving a complete remission of wheezes- will be the best, thing for you in the long run". After several months of unhappiness and failure to convince the physician of the importance of her personal goals as well as her medical goals, she sought another physician, insisting that she didn't live just to breathe, but breathed so that she could dance[22].

As in this case -and despite the claims of several commentators- people with medical needs generally do not confront physicians as strangers and as adversaries in contemporary health care. As we suggested earlier, even if they can be viewed as strangers in that they often do not know each other prior to the encounter, both parties may well proceed with a presumption of trust. Patients may approach physicians with some trust and confidence in the medical profession, even though they do not know the physicians before them. Indeed, codes of medical ethics have been designed in part to foster this trust by indicating where the medical profession stands and by creating a climate of trust. Thus, even if patients approach individual physicians as strangers, they may have same confidence in these physicians as members of the profession as they negotiate the particular terms of their relationship. At the other extreme, some patients may approach physicians as adversaries or opponents. But for negotiation to proceed, some trust must be present, even if it is combined with some degree of control, for example, through legal requirements and the threat of legal sanctions.

The general public trust in the medical profession's values and skills provides the presumptive basis for trust in particular physicians and can facilitate the process of negotiation. But, as we noted earlier, in a pluralistic society, even people who are strangers, i.e., who share very few substantive values, may be 'friendly' if they share procedural values. Certain procedural values may provide the most important basis for the trust that is necessary for negotiation; indeed, procedural principles and rules should structure the negotiation in order to ensure equal respect for the autonomy of all the parties.

First, the negotiation should involve adequate disclosure by both parties. In this process of communication -much broader and richer than most doctrines of informed consent recognize- both parties should indicate their values as well as other matters of relevance. Without this information, the negotiation cannot be open and fair. **Second**, the negotiation should be voluntary; i.e., uncoerced. Insofar as critical illness can be viewed as 'coercing' individuals through the creation of fear, etc., it may be difficult to realize this condition for patients with certain problems. However, for the majority of patients this condition is achievable. **Third**, the accommodation reached through the negotiation should be mutually acceptable[23].

What can we say about the case of the ballet dancer in the light of these procedural requirements for negotiation? It appears that the relationship foundered not because of inadequate disclosure at the outset, or along the way, but because of the, patient's change in or clarification of her values and the physician's inability to accommodate those other values. The accommodation reached at the outset was rnutually acceptable for a time. Initially their values and their metaphors for their relationship were the same. The physician regarded himself as a masterful scientist who was capable technically of controlling a patient's symptoms of wheezing. In fact, he remarked on several occasions: "I have never met a case of asthma I couldn't help". The patient, for her part, selected the physician initially for the same reasons. She was unhappy that her wheezing persisted, and she was becoming discouraged by her chronic health problem. Because she wanted a therapeutic success, she selected an expert who would help her achieve that goal. Both the patient and the physician made several voluntary choices. The patient chose to see *this* physician and to see him for several months, and the physician chose to treat asthma aggressively with steroids.

In a short time, the patient reconsidered or clarified her values, discovering that her dancing was even more important to her than the complete remission of wheezing, and she wanted to renegotiate her relationship so that it could be more mutual and participatory. But her new metaphor for the relationship was incompatible with the physician's nonnegotiable commitment to his metaphor, which the patient had also accepted at the outset. Thus, the relationship collapsed. This case illustrates both the possibilities and the limitations of the model of negotiation. Even when the procedural requirements are met, the negotiation may not result in a satisfactory accommodation over tim, and the negotiation itself may proceed in terms of the physician's and the patient's metaphors and models of the relationships, as well as the values they affirm.

Autonomy constrains and limits the negotiations and the activities of both parties: Neither party may violate the autonomy of the other or use the other merely as a means to an end. But respecting autonomy as a constraint and a limit does not imply seeking it as a *goal* or praising it as an *ideal*[24]. This point has several implications. It means, for example, that patients may exercise their autonomy to turn their medical affairs completely over to physicians. A patient may instruct the physician to do whatever he or she deems appropriate: "You're the doctor; whatever you decide is fine". This relationship has been characterized as "paternalism with perrnissiont"[25], and it is not ruled out by autonomy as a constraint or a limit. It might, however, be ruled out by a commitment to autonomy as an ideal. Indeed, commitment to autonomy as an ideal can even be paternalistic in a negative sense; it can lead the health care professional to try to force the patient to be free and to live up to the ideal of autonomy. But our conception of autonomy as a constraint and a limit prevents such actions toward competent patients who are choosing and acting voluntarily. Likewise, maintenance, restoration, or promotion of the patient's autonomy may be, and usually is, one important goal of medical relationships. But its importance can only be determined by negotiation between the physician and the patient. The patient may even subordinate the goal of autonomy to various other goals, just as the ballet dancer subordinated freedom from wheezing to the power to dance.

This view of autonomy as a limit or a constraint, rather than an ideal or a goal, permits individuals to define the terms of their relationship. Just as it permits the patient to acquiesce in the physician's recommendations, it permits the physician to enter a contract as a mere technician to provide certain medical services, as requested by the patient. In such an arrangement, the physician does *not* become a mere means or a mere instrument to the patient's ends. Rather, the physician exercises his or her autonomy to enter into the relationship to provide technical services. Such actions are an expression of autonomy, not a denial of autonomy. If, however, the physician believes that an action requested by the patient -for example, a specific mode of therapy for cancer or a sterilization procedure- is not medically indicated, or professionally acceptable, or in the patient's best interests, he or she is not obligated to sacrifice autonomy and comply. In such a case, the professional refuses to be an instrument of or to carry out the patient's wishes. When the physician cannot morally or professionally perform an action (not legally prohibited by the society) he or she may have a duty to inform the patient of other physicians who might be willing to carry out the patient's wishes. A refusal to be an instrument of another's wishes is very different from tying to prevent another from realizing his or her goals.

Negotiation is not always possible or desirable. It is impossible, or possible only to a limited extent, in certain clinical settings in which the conditions for a fair, informed, and voluntary negotiation are severely limited, often because one party lacks some of the conditions for autonomous choices. **First**, negotiation may be difficult if not impossible with some types of patients, such as the mentally incompetent. Sometimes paternalism may be morally legitimate or even morally obligatory when the patient is not competent to negotiate and is at risk. In such cases, parents, family members, or others may undertake negotiation with the physician, for example, regarding defective newborns or comatose adults. But health care professionals and the state may have to intervene in order to protect the interests of the patient who cannot negotiate directly. **Second**, the model of negotiation does not fit situations in which patients are forced by law to accept medical interventions such as compulsory vaccination, involuntary commitment, and involuntary psychiatric treatment. In such situations, the state authorizes or requires treatment against the wishes of the patient; the patient and the physician do not negotiate their relationship. **Third**, in some situations physicians have dual or multiple allegiances, some of which may take priorty over loyalty to the patient. Examples include military medicine, industrial medicine, prison medicine, and university health service. The physician is not free in such settings to negotiate in good faith with the patient, and the patient's interests and rights may have to be protected by other substantive and procedural standards and by external control. **Fourth**, negotiation may not be possible in some emergencies in which people desperately need medical treatment because of the risk of death or serious bodily harm. In such cases, the physician may *presume* consent, apart from a process of negotiation, if the patient is unable to consent because of his/her condition or if the process of disclosing information and securing consent would consume too much time and thus endanger the patient. **Finally**, procedural standards are important for certain types of patients, such as the poor, the uneducated, or those with 'unattractive medical problems' (e.g., drug addiction, obesity' and hypochrondriasis). In such cases, there is a tendency -surely not a universal one- to limit the degree of negotiation with the patient because of social stigmatization. A patient advocate may even be appropriate.

In addition to the procedural requirements identified earlier, there are societal constraints and limits on negotiation. Some actions may not be negotiable. For example, the society may prohibit 'mercy killing', even when the patient requests it and the physician is willing to carry it out[26]. Such societal rules clearly limit the autonomy of both physicians and patients, but some of these rules may be necessary in order to protect important societal values. However,

despite such notable exceptions as 'mercy killing', current societal rules provide physicians and patients with considerable latitude to negotiate their own relationship and actions within that relationship.

If negotiation is a process, its accommodations at various points can often be characterized in terms of the above models: parent child, friends, partners, contractors, and technician-consumer. Whatever accommodation is reached through the process of negotiation is not final or irrevocable. Like other human interactions, medical relationships change over time. They are always developing or dissolving. For example, when a patient experiencing anginal chest pain negotiates a relationship with a cardiologist, he may not have given or even implied consent to undergo coronary angiography or cardiac surgery if the cardiologist subsequently believes that it is necessary. Medical conditions change, and people change; often clarifying or modifying their values over time. In medical relationships either the physician or the patient may reopen the negotiation as the relationship evolves over time and may even terminate the relationship. For example, the ballet' dancer in the case discussed above elected to terminate the relationship with the specialist. That particular relationship had not been fully negotiated in the first place. But even if it had been fully negotiated, she could have changed her mind and terminated it. Such an option is essential if the autonomy of the patient is to be protected over time. Likewise, the physician should have the option to renegotiate or to withdraw from the relationship (except in emergencies), as long as he or she gives adequate notice so that the patient can find another physician.

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NOTES

1. On metaphor, see **George Lakoff and Mark Johnson**, *Metaphors We Live By* (Chicago: University of Chicago Press, 1980).
2. See **Thomas S. Szasz and Marc H. Hollender**, 'A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship'. *Archives of Internal Medicine* 97, (1956) 585-92; see also, Thomas S. Szasz, William F. Knoff, and Marc H. Hollender, 'The doctor-patient relationship and its historical context', *American Journal of Psychiatry* 115, (1958) 522-28.
3. For a fuller analysis *of* paternalism and its justification, see **James F. Childress**, *Who Should Decide? Paternalism in Health Care* (New York: Oxford University Press, 1982).
4. **Eric Cassell** 'Autonomy and ethics in action', *New England Journal of Medicine* 297, (1977) 333-34. Italics added. Partnership is only one of several images and metaphors Cassell uses, and it may not be the best one to express his position, in part because he tends to view autonomy as a goal rather than as a constraint.
5. According to **Robert Veatch**, the main focus of this model is "an equality of dignity and respect, an equality of value contributions". **Veatch**, 'Models for ethical medicine in a revolutionary age', H*astings Center Report* 2, (June 1972) 7. Contrast **Eric Cassell** who disputes the relevance of notions of "equality" and "inequality". *The Healer's Art: A New Approach to the Doctor Patient Relationship* (Philadelphia: J. B. Lippincott Company, 1976), pp. 193-94.
6. **Thomas S. Szasz and Marc H. Hollender**, 'A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship', pp.586-87. (See Note 2.)
7. See, for example, **Paul Ramsey**, 'The ethics of a cottage industry in an age of community and research medicine', *New England Journal of Medicine* 284, (1971) 700-706; *The Patient as Person. Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), esp. Chap. 1; and **Hans Jonas**, 'Philosophical

reflections on experimenting with human subjects', Ethical Aspects of Experimentation with Human Subjects, *Daedalus* 98, (l969) 219-47.

8. **Robert Veatch**, 'Models for ethical medicine in a revolutionary age', p. 7. (See Note 5).
9. See **Roger Masters**, 'Is contract an adequate basis for medical ethics?', *Hastings Center Report 5,* (December 1975) 24-28. See also **May**, 'Code and covenant or philanthropy and contract?', in *Ethics in Medicine: Historical Perspectives and Contemporary Concerns,* ed. by Stanley Joel Reiser, Arthur J. Dyck, and William J. Curran (Cambridge, Mass.: The MIT Press, 1977), pp. 65-76.
10. **P. Lain Entralgo**, *Doctor and Patient*, trans. from the Spanish by Frances Partridge (New York: McGraw-Hill Book Co., World University Library, 1969), p. 242.
11. Ibid.,p.197.
12. See **Charles Fried**, *Medical Experimentation: Personal Integrity and Social Policy* (New York: American Elsevier Publishing Co., Inc., 1974), p. 76. Our discussion of Fried's position is drawn from that work, *Right and Wrong* (Cambridge, Mass.: Harvard University Press, 1978), Chap. 7, and 'The lawyer as friend: The moral foundations of the lawyer-client relation', *The Yale Law Journal* 85, (1976) 1060-89.
13. **Immanuel Kant**, *The Doctrine of Virtue,* Part II of *The Metaphysic of Morals,* trans. by Mary J. Gregor (New York: Harper and Row, Harper Torchbook, 1964), p. 140.
14. **Thomas S. Szasz, William F. Knoff, and Marc H. Hollender**, 'The doctor-patient relationship and its historical context', p. 525. See also Robert Veatch, 'Models for ethical medicine in a revolutionary age', p. 5, and Leon Kass, 'Ethical dilemmas in the care of the ill: I. What is the physician's service?', *Journal of the American Medical Association* 244, (1980) 1815 for criticisms of the techrical mode (from very different normative positions).
15. **Veatch**, 'Model for ethical medicine in a revolutionary age', P. .7.
16. See **Stephen Toulmin**, 'The tyranny of principles', *Hastings Center Report* 11, (December 1981) 31-39.
17. On trust and control, see **James F. Childress**, 'Nonviolent resistance: Trust and risktaking', *Journal of Religious Ethics* 1, (1973) 87-112.
18. **Talcott Parsons**, *The Structure of Social Action* (New York: The Free Press, 1949), p.311.
19. On the factors in the decline of trust, see **Michael Jellinek**, 'Erosion of patient trust in large medical centers', *Hastings Center Report* 6, (June 1976) 16-19.
20. **Alasdair MacIntyre**, 'Patients as agents', in *Philosophical Medical Ethics: Its Nature and Significance,* ed. by Stuart F. Spicker and H. Tristram Engelhardt, Jr. (Boston: D. Reidel Publishing Co., 1977).
21. **John Ladd**, Legalism and medical ethics, *The Journal of Medicine and Philosophy* 4, (March 1979) 73.
22. This case has been presented in **Mark Siegler**, 'Searching for moral certainty in medicine: A proposal for a new model of the doctor-patient encounter', *Bulletin of the New York Academy of Medicine* 57, (1981) 56-69.
23. See ibid. for a discussion of negotiation. Other proponents of a model of negotiation include **Robert A. Burt**, *Taking Care of Strangers: The Rule of Law in Doctor-Patient Relations* (New York: Free Press, 1979) and Robert J. Levine, *Ethics and Regulation of Clinical Research* (Baltimore: Urban and Schwarzenber, 1981).
24. See the discussion in **Childress**, *Who Should Decide?,* Chap. 3.
25. **Alan W. Cross and Larry R. Churchill** 'Ethical and cultural dimensions of informad consent', *Annals of Internal Medicine* 96, (1982) 110 - 113.
26. See **Oscar Thorup, Mark Siegler, James Childress, and Ruth Roettinger**, 'Voluntary exit: Is there a case of rational suicide?', *The Pharos* 45, (Fall 1982) 25-31.