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 some features and hide other features of their principal subject. 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.
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. 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 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 justified.

A second model is one of *partnership*, which can be seen in Eric Cassell’s