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Re-modelling the Space of Healing: Interpersonal and Spatial Configurations

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The Veterans Memorial Building located in Cedar Rapids, Iowa.

We investigate models that might move away from the traditional biomedical approach by emphasizing collaborative decision-making, patient autonomy, and considering psychological and social factors in addition to biological ones in the therapeutic relationship. Can a reconfiguration architecture affect this therapeutic space?

Western Modern Medicine historically

Larry Dossey describes three eras of modern, Western medicine. Beginning about the 1860's [1],

Era 1 focused on the mechanical physical components of medicine. "...Physicians see a body that is made up of 'things' - organ systems such as the cardiovascular system; specific organs such as the liver; individual cells that comprise the organs… Summing all these 'things', the physician arrives at a definition of the body.

This is the 'classical body' - a concrete entity that occupies a particular position in space, a thing that is confined to a point in time, an entity that endures for a particular span of time, the behavior of which can be described as obeying the common sense laws of cause and effect..." [2]. As a result, the mind is a result of brain functions. When soldiers came home from World War I suffering from shell shock, the effects of Era 1 with antibiotics, vaccines, and irradiation, didn't include the idea that the mind effects the body. The notion of mental health was not addressed. However, after World War II, research in psychosomatic disease gave rise to Era II, the mind-body era.

Era II is what many alternative forms of therapy, such as biofeedback, tragerwork, Qigong, massage therapy, chiropractic, and meditation to name a few, are based upon. Evidence suggested the mind did affect the body. For instance, when under stress, rats and humans reacted similarly such as developing ulcers, hypertension, and heart disease [3].

Mind-body reactions could also be positive as demonstrated with the placebo effect - positive results emerge using positive thinking and 7 suggestion. Some researchers, utilizing an Era II thinking have studied the link between emotions, attitudes, and thoughts. Many of these scholars have utilized a biochemical perspective which equates the mind with the brain and central nervous system. However, many other researchers interested in alternative, complementary medicine view the mind as more than the physical brain and central nervous system. For them, the mind includes psychological and spiritual factors. According to Dossey, Eras I and II are considered local medicine because it involve hands on, visual, common sense everyday experience; local events seem well-behaved [4].

Era III, on the other hand, involves "nonlocal events" which seem to defy the common sense of classical physics. The term "nonlocal," which comes from the theories of modern physics, say events and consciousness are unbounded by time or space. Events such as distant healing, prayer, precognitive dreams, and intuition transcend classical assumptions about time and space and are, perhaps, better understood as nonlocal events. Three aspects of nonlocal events that are relevant to healing are as follows: nonlocal events aren't transmitted by any type of force or energy; the strength of the correlated change doesn't weaken with distance; the nonlocal events occur immediately.

In Era III, nonlocal medicine views the mind as more than the brain; it exists freely in space and time. According to Dossey, Eras I and II perspectives do not explain all phenomena and illnesses that exist. Dossey [5] proposes "as you read these words, a part of your mind is not present in your body or brain or even in this moment. Dossey cites experiments supporting Era III distant healing. Healers from Christian, Jewish, Buddhist, Native American, shamanic practices, and three other healing traditions were to focus their mental energies on AIDS patients an hour a day, six days a week, for ten weeks. Psychological tests were given so that the patients' belief systems didn't affect which group they were in. A blind review of the patients' charts revealed that patients who received distant healing intentions "had undergone significantly fewer new AIDS-related illnesses, had less severe illnesses, required few hospitalization, and fewer days of hospitalizations".

At the same time there was significant research and interest in alternative, non-traditional Western healing spaces and approaches. Examples include:

1. There has been a substantial increase in the use of alternative forms of healing in the United States. A 1998 survey found a 47.3% increase in visits to alternative practitioners from 1990 to 1997, with estimated out-of-pocket expenditures of $27 billion in 1997 [6].
2. Sacred spaces and spirituality have long been used to heal the mind, body, and spirit. Ancient societies created dedicated healing environments, such as the Greek healing city of Epidaurus, which incorporated both spiritual and scientific healing modalities [7].
3. Outdoor therapy and nature-based healing approaches are gaining attention as alternatives to traditional indoor therapy settings. A study examined the experiences of Black clinicians working with Black clients in outdoor therapy settings, finding that nature can serve as a therapeutic medium facilitating physical, physiological, and emotional healing [8].
4. Indigenous and non-Western healing practices often emphasize interconnectedness and balance among elements of human existence, in contrast to Western psychological traditions that tend to distinguish between physical, mental, and spiritual well-being [9].
5. Many traditional healing systems place emphasis on the spirit world, supernatural forces, and religion. For example, in Africa, health is often viewed as a balance between the individual and the cosmos [10].
6. Researchers and practitioners are exploring ways to integrate alternative healing approaches into mainstream healthcare. This includes creating therapeutic alliances with indigenous healers, understanding the benefits of both Western and non-Western approaches, and developing more holistic, spiritually-informed practices [11].
7. There are challenges in scientifically measuring the efficacy of some alternative healing methods, particularly those involving energy or spiritual components. Researchers suggest using a combination of quantitative and qualitative methods, including ethnographic studies and in-depth interviews, to better understand these practices [12].

Overall, the research indicates a growing interest in and acceptance of alternative, non-traditional Western healing spaces and approaches, with efforts being made to integrate these practices into mainstream healthcare while respecting their unique cultural and spiritual foundations.

All the while these researchers still maintained the validity and philosophical underpinnings of the western bicameral model of healing and thereby integrate newer techniques with traditional modes.

1. This includes creating therapeutic alliances with indigenous healers, understanding the benefits of both Western and non-Western approaches, and developing more holistic, spiritually-informed practices.
2. There are challenges in scientifically measuring the efficacy of some alternative healing methods, particularly those involving energy or spiritual components. Researchers suggest using a combination of quantitative and qualitative methods, including ethnographic studies and in-depth interviews, to better understand these practices.

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In our revised model the outer space between the physician and healer must place a role (the right hemispheric function per Ian McGilchrist model.

Sacred space and spirituality

Sacred spaces for healing have long been used to heal the mind, body, and spirit.

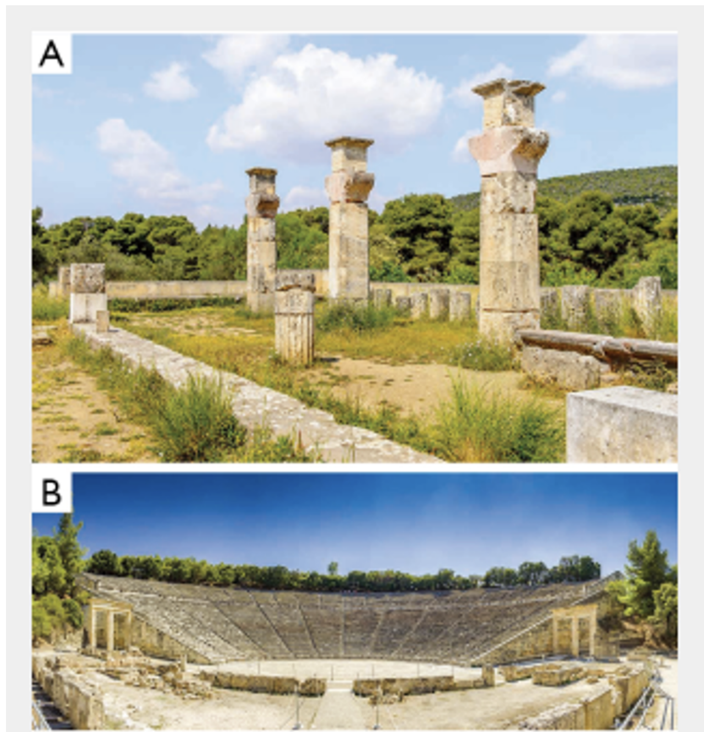


Image of the theater at Epidaurus, Greece.

(A) This image is of the ruins of the Abaton, the place where sleeping or "incubation" and dream healing occurred at Epidaurus, Greece.
(B) Image of the theater at Epidaurus, Greece.

The origins of sacred space and its role as a healing environment has been around from the first human construct, the burial mound, to the 5th Century BCE Greek healing city of Epidaurus. About 2,500 years ago, the Greeks had been engaged in continuous warfare for centuries, which profoundly affected a society's collective health as well as an individual's well-being period. The Greek Society needed a space like Epidaurus [13].

The city evolved into a sanctuary site dedicated to heroes and the gods. The healing cult of Asklepios became the primary god of worship early in the 5th Century BCE. While primary healing activity took place in the Asklepian (temple), the entire city of Epidaurus was utilized as a healing environment, integrating sacred space, profane space and healing rituals. The ancient city's location also realized two important, evidence-based principles of modern healthcare design: views of nature and the incorporation of sunlight.

The selection of Epidaurus' building site was a critical design concern: the ancient Greeks knew how to select for the residences of their gods the most suitable locations in their country. The enchantment the pleasant Plain of Epidaurus proffers the visitor even today was probably one of the reasons why the sanctuary was established there. The climate is mild. The tranquil greenery would, even then, have furnished the sick pilgrims with relaxation and serenity. The sanctuary was also called the Sacred Grove. The plenteous spring waters were another influential factor. The architectural environment described supports a menu of active and passive healing activities that range from solitary prayer to the viewing of Community Theater. While the Asklepian was the center of healing activity, Epidaurus' other support spaces provided essential healing dimensions that allowed the pilgrim to customize their healing journey. That the role of spirituality was one of the necessary human institutions for a healthy society, was recorded by the Italian philosopher Giambattista Vico [14].

Giambattista Vico was the 18th century author of New Science (Scienza Nuova), a book that interprets the ancient myth of Homer's *Iliad* and *Odyssey*, not as fantastical stories, but as historical events.

Vico deconstructs Homer's poetry for psychological archetypes, the origins of society and the human institutions necessary for civic discourse. He identified three such institutions essential for the founding and sustenance of a society:

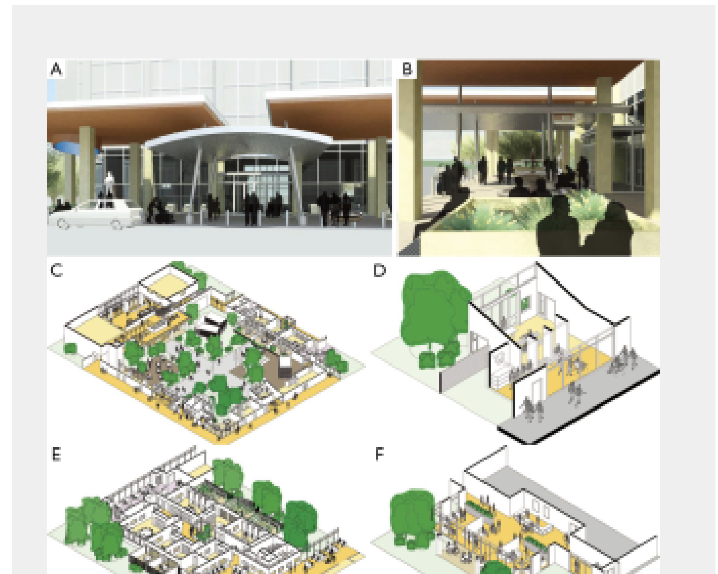
I. Divine providence—belief in god.
II. Solemn matrimony—the importance of family and procreation and sacred nuptials.
III. Burial—the universal belief in the immortality of the soul and importance of personal and collective memory.

Spirituality was a common thread in all Vico's three human institutions. These sacred institutions were manifested in Italian architecture and integrated into the urban and community fabric. The center of the city contained a piazza composed of sacred, civic, residential and commercial space.

The piazza provided a venue for incidental meetings, community events, commerce and religious festivals. But it was the basilica that stood as the place of moral authority, worship, nuptials and burial rites in Italian society. While adjacent to the profane world, the basilica possessed a boundary defining its domain: what has been said will make it clear why the church shares in an entirely different space from the buildings that surround it. Within the sacred precincts the profane world is transcended.

Image of the interior of the dome of the Church of Gesu located in Rome, Italy.

On the most archaic levels of culture this possibility of transcendence is expressed by various images of an opening; here, in the sacred enclosure, communication with the gods is made possible; hence there must be a door to the world above, by which the gods can descend to earth and man can symbolically ascend to heaven. This was the case in many religions; properly speaking, the temple constitutes an opening in the upward direction and ensures communication with the world of the gods.



Schematic representation of the hierarchy and continuum of natural systems as applicable to Engel's definition of the biopsychosocial model [15].

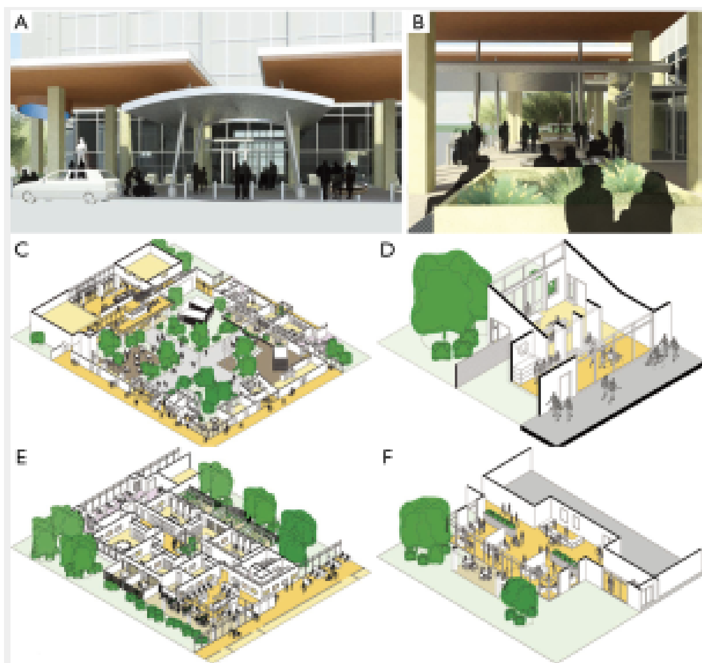
Application of sacred space in a secular model

The VAHEDG [16], a design guideline, was created for the purpose of collaboration between Veterans, medical providers, VA facilities staff, architects, and engineers in the creation of healing environments for VA medical centers and VA community based outpatient clinics (CBOC). A healing environment facilitates a Veterans' healing journey by fusing therapeutic environments with healing programming for the restoration of their mind, body, and spirit.

The Office of Construction and Facilities Management of the Department of Veteran Affairs commissioned this healing environment design guideline.

"*The impetus for the HEDG began in 2010 when VA launched a major initiative with the formulation of the Office of Patient Centered Care and Cultural Transformation (OPCC & CT). The term 'Healing Environment' was being applied to all facets of the physical environment and the associate facility planning and design work and it became clear there was no common definition or common understanding of what constitutes a 'healing environment'. In addition to OPCC&CT the VA Environmental Management Service (EMS) was initiating efforts to define and describe 'healing environments' in VA facilities*."

A healing environment (HE) should encompass the whole facility, with each room and adjacent exterior element contributing to a different aspect of a Veteran's healing.



The Department of Veteran Affairs Healing Environment Design Guideline.

(A) Image of proposed canopy for the exterior waiting area adjacent to the main reception lobby for VA Medical Centers.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

(B) Image of the exterior waiting area adjacent to the main reception lobby containing: seating, planters, and a fountain.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

(C) Image of axonometric view of the therapeutic courtyard adjacent to the main reception lobby, the outpatient mental health clinic, multi-purpose room chapel, and small waiting rooms and places for meditation.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

(D) Image of an axonometric view of a proposed chapel adjacent to an interior courtyard and interior corridor of the VA Medical Center.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

(E) Image of an axonometric view of the outpatient mental health clinic adjacent to the proposed interior courtyard and interior corridor of the VA Medical Center.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

(F) Image of an axonometric view of outpatient waiting area to a proposed outpatient clinic adjacent to an interior courtyard and corridor of the VA Medical Center.
Source: The Department of Veteran Affairs Healing Environment Design Guideline.

Not every day is the same in a healing journey with stress related to family, job, and other personal issues that may complicate therapies related to wounds acquired during service. To reduce a Veteran's stress the guidelines have identified seven design principles that compose a healing environment:

How do different sensory stimuli in healing spaces contribute to emotional regulation?

Our claim suggests that different sensory stimuli in healing spaces contribute significantly to emotional regulation in several ways:

1. Multi-sensory stimulation: Healing spaces that incorporate various sensory elements like nature views, interior plants, soothing colors, textures, and natural light create a multi-sensory environment that can positively impact emotional regulation [17].
2. Creating positive spatial atmospheres: Healing structures can enhance the emotional experience of a space by creating a positive spatial atmosphere, which in turn helps optimize emotional regulation [18].
3. Promoting calmness: Specific color schemes, such as green and blue, can be used in healing spaces to promote a sense of calm and contribute to emotional regulation.
4. Nature-inspired elements: Incorporating nature-like patterns on walls or creating biophilic environments can help reduce stress and promote emotional balance.
5. Flexibility in design: Spaces with flexible partitions and adjustable layouts allow for customization to meet individual sensory needs, supporting better emotional regulation. Sensory rooms: Dedicated sensory rooms in healthcare facilities, when designed properly, can provide a controlled environment for patients to explore and regulate their sensory experiences, leading to improved emotional regulation.
6. Connection to nature: Semi-open spaces connected to nature or incorporating natural elements can create a biophilic environment that supports stress relief and emotional regulation.
7. Meditation spaces: Incorporating areas for meditation or mindfulness practices can offer multi-sensory experiences that help relieve stress and promote emotional balance.
8. Arousal level management: Different sensory stimuli can help manage arousal levels, which is crucial for emotional regulation. This can involve creating spaces that either stimulate or calm the senses, depending on individual needs.
9. Supporting attention and focus: Well-designed sensory environments can help improve attention and focus, which are important components of emotional regulation [19].
10. Promoting self-exploration: Therapeutic rooms with appropriate sensory stimuli provide spaces for self-exploration, allowing individuals to better understand and manage their emotional responses.

By carefully considering and incorporating these various sensory elements, healing spaces can create environments that actively

support and enhance emotional regulation for patients, particularly those with mood disorders or other emotional challenges.

Nontraditional Interactions Between Doctor and Patient.

There is growing evidence supporting the importance and effectiveness of alternative doctor-patient relationships on healing outcomes:

1. Holistic approaches to doctor-patient communication are challenging, as studies show patients often don't understand medical terms the same way doctors do. A non-holistic view suggests that minimal shared understanding may be sufficient for communication in many cases [20].
2. Challenging interactions can arise due to discrepancies in expectations, perceptions, and communication between doctors and patients. Common scenarios include delivering bad news insensitively, poor nonverbal communication, patients demanding specific treatments based on online research, or patients not accepting diagnoses [21].
3. The traditional doctor-patient relationship is evolving due to factors like managed care, direct-to-consumer advertising, and increased access to medical information online. While some changes like more knowledgeable patients can be positive, others like managed care restrictions may negatively impact the relationship [22].
4. There's a need to balance the doctor's medical expertise and decision-making with patient autonomy. Courts have ruled that hospitals and drug manufacturers should not interfere with physicians' independent medical judgment and practice [23].
5. Socioeconomic and sociocultural factors can significantly affect doctor-patient relationships. Issues like substance abuse, insurance status, use of home remedies, religious beliefs, and patient autonomy (especially for minors) all impact these interactions [24].
6. Cultural sensitivity is crucial for building positive doctor-patient relationships. Providers need to be aware of potential cultural differences in how patients view health issues, seek treatment, and react to care plans [25].
7. Communication barriers due to medical terminology or education level differences need to be bridged. Doctors should use simple terms and assess patients' medical knowledge base [26].

A study [27] on healing relationships in primary care identified three key processes that foster healing relationships between clinicians and patients:

1. Valuing/creating a nonjudgmental emotional bond
2. Appreciating power/consciously managing clinician power to benefit the patient
3. Abiding/displaying commitment to caring for patients over time

These processes led to relational outcomes of trust, hope, and a sense of being known by the patient.

Research [29] has found that certain aspects of clinician-patient relationships are related to improved health outcomes, including:

- Lower morbidity and mortality
- Better treatment adherence
- Improved health status
- Better clinical outcomes for conditions like diabetes

A study examining patients' healing journeys found that forming safe, trusting relationships with helpers (including but not limited to doctors) was crucial for patients to gain resources and attributes that contributed to healing, defined as "recovering a sense of integrity and wholeness after experiencing illness and suffering".

The therapeutic alliance between doctors and patients has been shown to enhance medication adherence in patients with schizophrenia, leading to improved outcomes, reduced dropouts, and fewer hospital admissions. Trust in the doctor-patient relationship has beneficial effects on treatment outcomes. Studies have found that trust behavior is modulated by oxytocin, which enhances social cognition and helps in better engagement. Patient satisfaction has been associated with doctors showing more interest, making eye contact, and responding emotionally through non-verbal communication. While the traditional doctor-patient dynamic remains important, these findings suggest that alternative approaches emphasizing trust, emotional bonds, patient empowerment, and sustained caring relationships can positively impact healing and health outcomes. However, more research may be needed to quantify the specific effects of different relationship models across various medical contexts.

Providers and Physicians [29].

From ancient times until the 1970s, physicians were guided by the principle of beneficence (looking out for the good of the patient as they understood it and acting unilaterally in decision making). Indeed, physicians practiced beneficence to the point of paternalism. Doctors focused on the patient's illness, and since she had the expertise to know the best course of treatment for that illness, she thought it best for the patient to act upon that knowledge without worrying the patient.

In the 1970s the doctor patient dynamic began to change dramatically with a growing recognition of the importance of patient autonomy in decision making. Instead of being the passive recipient of the medical care administered by their physicians, patients became active participants in the doctor patient relationship. In their beneficence doctors may strongly recommend a specific treatment plan but the patient has the right to be informed of the therapeutic options and the right to make the final decision. Autonomy requires the informed consent of the patient, which includes full disclosure of information in a way he understands and to which he fully consents without any outside constraint. Certain aspects of the relationship between providers and patients are generally accepted and relatively uncontroversial. The relationship is seen as fiduciary, meaning that it is based on trust. The patient trusts the provider with his or her healthcare and the provider is expected to fulfill certain duties toward the patient. Obligations toward patients include:

- Technical competence in the provider's area of expertise
- Acting so as avoid harming the patient (non-maleficence)
- Acting for the patient's benefit (beneficence)
- Keeping patient information confidential (under normal circumstances)

The provider is also considered to be a professional. A profession has standards and expectations about such matters as established methods of specialized training, possession of proper certification, mastery of requisite skills, possession of authoritative knowledge, expectations of appropriate behavior and judgment, high quality of performance, devotion to the area or field of expertise, and codes of ethical conduct. The American Medical Association Code of Ethics [30] provides guidance on what they consider the proper relationship between physicians and patients. Besides what is mentioned above, physicians should, among other things, avoid exploiting patients, avoid engaging in sexual relations with patients, and respect the rights of patients to make their own decisions about treatment and procedures.

The Paternalistic Model

In a healthcare context "paternalism" occurs when a physician or other healthcare professional makes decisions for a patient without the explicit consent of the patient. The physician believes the decisions are in the patient's best interests. But the control in the relationship resides with the physician rather than the patient, much as the control in a family resides with the parents and not the children.

In the traditional paternalistic model it was considered acceptable for the physician to decide what to tell the patient about the actual diagnosis, and in cases of terminal disease the patient was sometimes not told the true nature of the illness (perhaps the family was told instead). Or if the patient were informed of the diagnosis, the physician might present the recommended treatment plan as the only one rather than mentioning alternatives that could be considered. Or if the patient were told of alternatives, the physician might make the recommended treatment plan seem clearly preferable in order for it to be chosen.

Paternalism occurs outside healthcare. Typical parental decisions in a family are paternal in this way – the parents pick and choose what to tell their children, present only alternatives they favor, and make the important decisions. When the government requires seatbelt use or motorcycle operator helmet use, it acts in a paternalistic way. The government in such cases believes it is acting in the best interests of the citizens, but what makes it paternalistic is that the individual is not free to control the decision (without breaking the law).

It is inevitable that providers will act paternalistically in an innocuous sense for much of what goes on in healthcare. For example, a surgeon performing a surgical procedure on a patient will use the techniques he or she feels best fit the situation rather than asking the patient for advice or presenting choices to the patient about technique throughout the operation. Or in deciding upon medications to try to treat an infection, the provider will narrow down the field of possibilities to ones that in his or her professional judgment are likely to knock out the particular type of infection rather than presenting long lists of antibiotics to the patient so that the patient may choose. Or in deciding on what kind of continuing professional education conferences to attend or what professional literature to read, the provider will not solicit patients for advice but rather use his or her own judgment about what new knowledge and training will likely best benefit his or her patients. Controversy about provider paternalism is not about such issues but about such matters as not presenting treatment options to patients when the medical consensus is that there are several options or choosing among several viable treatment options without patient input, or not being honest with the patient about a diagnosis.

Arguments for Paternalism

One common argument for paternalism in healthcare is that the physician or other provider has such vastly superior technical knowledge of the medical situation -- the certainty of the diagnosis, the nature of the treatment options and possible benefits, and the risks involved - that it makes more sense for the provider to evaluate the options and make the decisions. Patients are easily overwhelmed by technical details and risk talk and are therefore not in the best position to make the decision. The patient suffering from an illness will often be in a weakened and vulnerable state and has come to the provider seeking expert advice, help, and judgment that the patient lacks. Furthermore, any decision should be made rationally, on the basis of an objective evaluation of the facts, rather than on emotion. The patient is usually very emotionally involved

and possibly frightened by all the talk of risks and uncertainties, and this might affect the patient's judgment. The physician is less emotionally involved in the situation and can better make the right choice. In fact, upsetting information presented to the patient could harm the patient by throwing him or her into sadness and depressing, and the physician has an obligation not to harm the patient.

Arguments against Paternalism

Paternalism makes two distinct assumptions:

1. The provider can properly withhold important information from and make significant decisions for the patient. It is morally permissible to do so.
2. The provider in fact knows what is best for the patient.

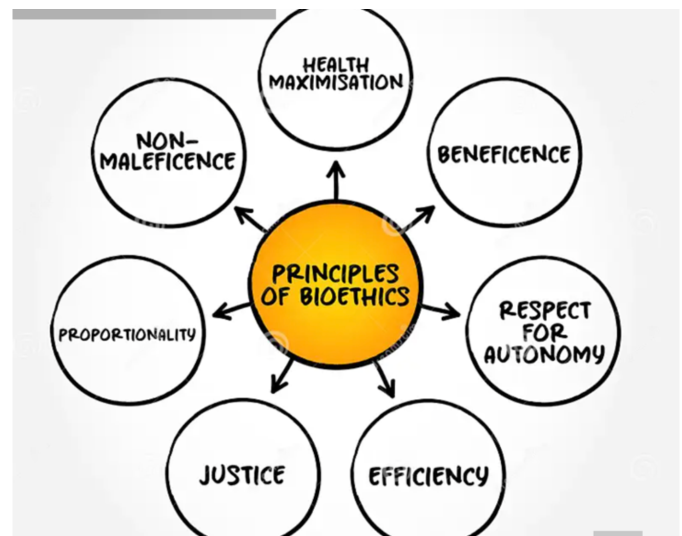
The first assumption has come under attack in recent decades through the emphasis on respect for patient autonomy. In the 1970's the general public became aware of past abuses in medical research. In some studies in the U.S. in previous years researchers failed to honestly inform research subjects about the true nature of the research; sometimes the subjects were blatantly deceived and put at risk of significant harm. As the public became aware of such abuse, there were calls for reform in research and healthcare, and a "bioethics" movement began to talk of principles of "respect for persons" and "respect for autonomy." [31].

"Autonomy" is the freedom and ability to control the course of one's own life instead of being controlled by others. Autonomy implies being able to decide of one's own free will instead of out of external restraint or coercion or the "internal" influence of drugs, alcohol, mental illness, or other emotional factors. Some believe that autonomy requires the choice must not be crippled by the lack of significant information.

If the autonomy of a patient or subject must be respected, the physician cannot properly withhold significant information and make major decisions for the patient or subject. That means that the following paternalistic practices would be, under normal circumstances, morally impermissible: [32]

- Failing to inform the patient of the true diagnosis
- Failing to disclose to the patient other available, acceptable treatment options and their risks
- Explicitly lying, withholding information, or being otherwise deceptive to patients
- Making important decisions for the patient instead of allowing the patient to make them (Exceptions might be made for child patients and emergency situations.)
- Presenting information or portraying options to the patient in such a manner that the patient cannot make an objective decision but will instead choose exactly what the provider wants
- The second assumption of healthcare paternalism mentioned above is that the provider in fact knows what is best for the patient. There are different possible interpretations of this.
- Knowing how everyone should live life and what they should want to get out of it.
- Knowing what a particular patient wants to get out of life because of candid discussions with the patient.
- Given a patient's own stated goals for what they want out of life, knowing what health goals (for example, freedom from chronic disease and infirmity, high state of aerobic fitness) they need to have to realize their life goals (for example, sailing around the world after retirement, seeing their grandkids graduate from college).
- Given the patient's own stated health goals, knowing what healthy practices (diet, exercise, medication, testing) they need to adopt to reach those health goals.

The critic of paternalism could claim that when a provider makes critical decisions for a patient or withholds important information so as to influence a patient's decisions, without involving the patient in the process, the provider seems to be implicitly assuming to know all about what type of life people in general should live and want to get out of life. But knowing all this would require settling controversial philosophical and religious questions that are not within the scope of medical expertise. The provider may know what the provider wants out of life, but the provider may not know what the patient wants to get out of life, and the provider most likely is not in a position to know what the patient should want to get out of life. For example, the provider should not simply assume that the patient would not want to be told of a terminal disease because maybe the patient would want that knowledge in order to allow him to take time to get his economic, personal, and spiritual affairs in order before death. Rather, the critic would claim, the provider should stick to learning from the patient what the patient wants out of life and advising the patient about health goals and practices that are likely to achieve the patient's life goals.



Non-paternalistic models

If paternalism is inadequate as the ideal model of relations between providers and patients, what should that relationship look like? Other models have been suggested to replace the paternalistic model. Two common groups of models are what we will call "technical" models and "shared-decision" models.

A technical model of the provider-patient relationship sees the provider supplying only technical medical expertise to the patient. Various versions of this type of model are called “informative,” “scientific,” “engineering,” “consumer,” etc. The physician diagnoses the disease, explains treatment options to the patient, along with anticipated benefits and potential risks, and gives the probably of favorable outcomes with each option, including discussion of which ones are most popular in the patient’s situation, but no significant time is spent discussing patient life or health goals and values, and the patient is given complete freedom to decide on their own what to do. The patient must consider what they want out of life, what risks they are willing to take, etc. and then decide what to do.

The technical type of model avoids the charge of paternalism because it does not assume that the provider should withhold information from or decide for the patient, and the provider does not presume to know what is best for the patient. But critics of technical models claim that while it might represent what we want out of an auto mechanic or a travel agent, it is probably not what most of us want from a healthcare provider.

Though people may not want the provider automatically making the important decisions, they often do want to discuss treatment options with the provider in the context of a discussion about their health and life goals and values. Many patients would welcome a provider-patient discussion about what they want out of life and how to get there. They want the provider’s appraisal of the options in light of the provider’s knowledge of the patient’s goals and values for health and life. Patients may not want the provider to make the decisions, but they want advice and recommendations. They don’t want coercion, but many would welcome dialogue. So many critics see technical models as too extreme a reaction to paternalism.

A middle-ground model tries to avoid the objections to paternalism but involve the provider more in the patient’s life than would technical models. These middle-ground models are called variously “mutual autonomy”, “shared decision”, “interpretive”, “collegial”, “deliberative”, etc. Not all of these models are the same. Middle-ground models differ in the degree of provider involvement in discussing, elucidating, and influencing patient goals and values and making decisions.

In what Emanuel and Emanuel call the “interpretive” model the physician helps the patient identify their values and explore which treatment options fit the health-related goals the patient may have [33]. A patient with a goal of staying physically fit would be interested in those treatment options that would tend to promote physical fitness. Going a little further, on the “deliberative” model the physician actually tries to persuade the patient to change health-related values if the physician thinks the patient has the wrong ones, but the physician stops short of coercing the patient to change. So, for example, if the patient lacks the health-related goal of avoiding heart disease, and smokes and eats to excess, the provider should try to persuade the patient to adopt that health-related goal and refrain from those risky practices. Emanuel and Emanuel prefer the deliberative model over the interpretive model.

Pellegrino offers a middle-ground type of model that attempts to combine aspects of paternalism and autonomy in his concept of “beneficence-in-trust”. [34] Beneficence should guide the provider’s actions toward the patient, but included in that beneficence is a respect for the autonomy and values of the patient. So, clearly, respect for patient autonomy should be present in the provider-patient relationship.

Edmund Pellegrino postulates several reasons for the ascendancy of patient autonomy in the doctor patient relationship: participatory democracy, increasing moral pluralism, weakening of religion as the ultimate source of morality, better public education, general mistrust of authority, reaction against expansion of medical technologies, and entry of professional philosophy in the study of medical ethics. Perhaps the last two reasons are of special importance [35]. With advances in modern technologies (in-vitro fertilization, organ transplantation, genomics, etc.) came a broad range of ethical dilemmas that transformed what was previously called medical ethics into a wider field we now call bioethics. One might say that theologians and physicians in past days were the key players in medical ethics, whereas in our day of rapid technological innovation philosophers and scientists have greater influence in the broader discipline of bioethics. And liberty which is the core principle of the liberal philosophical tradition is precursor of the principle of autonomy.

Autonomy is a necessary condition of beneficence. Knowledge of the patient’s own good should be gained through dialogue among the provider, patient, and family. However, it is recognized that ill patients are in a weakened state that may prevent them from being autonomous to the degree they otherwise would. In this compromised state, the patient comes to the provider for help and places trust in the beneficence of the provider.

It is likely true that many patients do trust the judgment of the provider about goals and values as they say, “tell me what you would do.” The provider then has an obligation to give advice that incorporates the patient’s own life goals and values, not the goals and values the provider happens to have for the provider’s life.

The closer middle-ground models get to involving the physician in the patient’s goals and values the more they open themselves to the charge of getting away from medicine and into personal lifestyle choices and life plans better left to philosophy and religion. To summarize, under paternalism the provider might withhold information about the disease or about treatments not preferred by the provider, or even decide for the patient. On technical models the provider would present all the facts and options and just let the patient figure it out on his own. On middle ground models the provider would engage the patient in a discussion about how the diagnosis and treatment options fit in with health-related goals and life goals. The controversy is about how far the provider should go in trying to convince the patient to live the life the provider would live rather than the life the patient seems to think he wants to live.

Comparing the Four Models

	Informative	Interpretive	Deliberative	Paternalistic
Patient values	Defined, fixed, and known to the patient	Inchoate and conflicting, requiring elucidation	Open to development and revision through moral discussion	Objective and shared by physician and patient
Physician's obligation	Providing relevant factual information and implementing patient's selected intervention	Elucidating and interpreting relevant patient values as well as informing the patient and implementing the patient's selected intervention	Articulating and persuading the patient of the most admirable values as well as informing the patient and implementing the patient's selected intervention	Promoting the patient's well-being independent of the patient's current preferences
Conception of patient's autonomy	Choice of, and control over, medical care	Self-understanding relevant to medical care	Moral self-development relevant to medical care	Assenting to objective values
Conception of physician's role	Competent technical expert	Counselor or adviser	Friend or teacher	Guardian

Table from Emanuel and Emanuel Four Models of the Physician-Patient Relationship [36].

Other Theoretical Models
In 1972 Robert Veach postulated four models of the doctor-patient relationship: [37]
(1) Priestly,
(2) Engineering,
(3) Collegial and
(4) Contractual.

The Priestly Model dates back to the Hippocratic tradition: "I will use treatment to help the sick according to my ability and *judgment*, but I will never use it to injure or wrong them". In other words, the physician makes all decisions regarding medical care of the patient based on his medical expertise and assessment of the patient's best interests, without consulting the patient. The Hippocratic, priestly physician operates on the *medical model*, which treats patients as illnesses, not as persons. The priestly physician does not take into account a patient's value system which includes a broad range of considerations beyond illness that might impact decision making. The paternalistic, Priestly Model of the doctor-patient relationship remained dominant from the time of Hippocrates (4th century B.C.) until the 1970s when Veach first wrote on the subject.

The Engineering Model switches the locus of decision making from physician to patient. The physician becomes a "hired gun" who relays the medical facts to the patient who then has full authority to select whichever treatment option he thinks is most consistent with his needs and desires, and then the physician implements the patient's decision. In this model, the physician is like a plumber who, hired by a client, uses the skills of his trade to make repairs and flush out clogged pipes. He is a reservoir of scientific knowledge and dispenser of medical facts, presenting options to the patient without sharing his personal recommendations.

In the Priestly Model the patient relinquishes his moral authority and puts full decision-making responsibility in the hands of the physician; contrariwise, in the Engineering Model the physician abdicates his moral authority, reduces his role to that of a scientific expert who presents medical findings in a factual, value-free way and then places the full responsibility of decision-making in the hands of the patient.

Over the past 4 decades the once dominant Priestly Model with its centuries-old Hippocratic ethic has lost ground to the Engineering Model which better describes the dominant physician-patient dynamic in the modern medical marketplace. The movement from primary care to specialization in the medical profession, with emphasis shifting from conversation with patients to performance of procedures, is one manifestation of its emergent influence. Another is the growing perception that medical care is a commodity to be bought and sold at a competitive price. Physicians are referred to as health care *providers*, not health care *professionals*; patients are *consumers* of a health *product*. Twenty years after Veach, Ezekiel Emanuel and Linda Emanuel proposed 4 Models of the physician-patient relationship (see above). The first two are very similar to Veach's: Paternal Model (like Priestly) and Informative Model (like Engineering). However, their two collaborative models (Interpretative and Deliberative) spell out the role of the physician in greater detail than Veach.

In the Interpretative Model, the physician acts like a counselor whose role is to elucidate and interpret the patient's values, and then to assist him in determining the medical interventions which would best realize the specified values. It presumes that people are often unclear about their values and that discussion with another would help them apply their value system to clinical situations. The counselor physician acts as a facilitator in the process and does not introduce his value structure into the discussion. He helps the patient reconstruct his goals and aspirations, his character and life commitments. Once the physician understands the patient's value system, he determines which tests and treatments would best realize these values. This final step resembles Veach's Contractual

Model since it's not necessary that patients be involved in every detail of decision-making once the patient's value structure is established. Yet in both models, the patient is the center of decision-making and has full moral authority.

In the Deliberative Model, the physician takes a much more active role in the collaborative dynamic. He presumes that the patient's values are open to development and revision through moral discussion. He articulates and persuades the patient of the most admirable values. Like a teacher he explains what course of action in his judgment is not only "medically indicated" (Informative Model) but also most noble. Thus, the physician presents his medical and moral judgment up front in the discussion and uses his skills of persuasion based on clinical experience and firm opinion, yet ultimately he leaves the final decision to the patient.

Theoretical models are helpful for discussion but do they apply in real life clinical medicine? In a provocative article entitled "No more models: just ask the patient", Clark et al. [38] argue that the common theoretical models of "preferred" decision making relationships do not correspond well with clinical experience. The theoretical models of doctor patient relationship treat the patient alone outside of his or her family and social context.

I would advocate that basing clinic practice upon theoretical models in fact does an injustice to the patient precisely because it leaves nothing to the improvisation of the ongoing and unfolding relationship and the back and forth between competing interests of the patient vs the physician.

The Enigma of Doctor-Patient Relationship

Vijaykumar Harbishettar et al. write: [39]

Doctor–patient relationship has been changing rapidly in this era of technological revolution. Patients, at home, can browse through a plethora of information about their condition and their available treatment. This means they now have a unique tool which when used appropriately can immensely benefit the patient and the doctor. However, as with new technology, changing culture and the shift toward more individualism and autonomy have made this information tool a double-edged sword. Internet sources of information can lead to patients' questioning the doctor's expertise and knowledge in terms of mental health and in turn, leading to conflicts in the relationship [40].

With this, physicians may get confused whether to debate regarding the understanding that patient has or to focus on rapport building for better treatment outcomes. The other possibility is the patient may decide to seek consultation with a second and subsequently a third doctor, thus losing out on the therapeutic benefit in the relationship. The courts expect the doctors to provide only a reasonable degree of care [41]. They have to bring in a reasonable level of knowledge and competence to exercise a reasonable degree of care, and the doctor does not have to ensure every person is cured. Trust is an integral part of any interpersonal relationships and has beneficial effects on treatment outcomes [42]. Some scientists have studied biology, where they found that trust behavior undergoes modulation by oxytocin enhancing social cognition and helping in better engagement [43]. There has to be reciprocity in terms of trust, and both parties have to develop professional ties with honesty and respect. There is a need to focus on one goal of improving the health of the patient to be achieved from the relationship.

Growing complaints, threats of complaints, abuse, and litigation makes doctors apprehensively assuming every patient is a potential litigant, and this kind of environment could further damage the trust the doctors have on patients, would be detrimental to the treatment outcomes, and overall impacts negatively on satisfaction over the health care system.

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