

Title: The “window mirror.” A new model of the patient-physician relationship

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Current, idealised models of the patient-doctor relationship focus solely on the care needs and interests of the patient (see Table 1). Physician needs are typically perceived as secondary in that they are not deliberately motivated by physician self-regard or by patient regard for the physician. However, this contravenes the ethical principle of taking into equal consideration all relevant and like interests in the patient-physician relationship. This paper explains the relevance of this principle; how it is challenged by decentering physician interests in the moral calculus of the patient-physician relationship; and why this corollary of the existing models demands *not* less attention to patients but rather a more egalitarian model that sharpens the focus on both parties in the patient-physician relationship. We will present such a model that illuminates and aids responsiveness to unmet interests of patients and physicians; at least where their interaction develops into a continuing relationship whose depth and breadth of context produce preconditions for care, as in family medicine [1].

Equal consideration of equal interests

Before discussing the principle of equal consideration of equal interests in care, we need to define what we mean by “care.” For us, this concept does not denote the provision of all medical services, as its often loose usage implies. It is, instead, “an activity defining a connectedness with and respectful attention to the concrete needs of others and self” [2]. It also involves an “intersubjective human process” [3], a socially constituted co-creation of shared, symbolic meaning that is an expressive and instrumental function of human behavior. Care therefore goes beyond the reciprocation occasioned by payment for services or even the benefit that accrues from being entrusted with human lives; it precludes a one-sided relationship in which “the patient remains the true focus” [4]. Although patients

and physicians have some different interests that require different consideration, these parties also share certain equal interests in the care defining their relationship. These equal interests include respect and not “suffering” stress needlessly, as through neglect of “self.”

Equal consideration of equal interests in care has two moral justifications, although the second is more usually put forward. First, it is based on the right – and, within the limits of what is reasonable in individual circumstances – the responsibility of physicians and patients to care and be cared about. This right and responsibility exist on the basis of shared “common sense” [5], common moral intuitions [6] or an “overlapping moral consensus” [7] that patients and physicians have equal inherent moral value. This moral value exists because patients and physicians are moral agents (and sentient beings). Their common morality is in our view external to medicine because the “ends of any practice such as medicine must come ... from the basic ends or purposes of ... living” whose determination requires philosophical and religious reflection [8]. Of course, it is always necessary to apply this common morality in context; for example, patients have reduced power and may be further weakened by anxiety, fear and sickness; physicians occupy roles with vested power. A result can be unequal capacities but each party has, and can serve in its own way, a common interest in care.

The second justification draws on the consequences of actions that consider, or not, equal interests. Not caring about physicians undermines respect for them, leaving their professional identity shaken; their morale, low [9]. Altruistic and frequently overworked, many physicians experience burnout [10]. They suffer, and their patients suffer the fallout. Patients’ interests are integrally connected to what also serves physician interests well. If physicians neglect, or do not care about, themselves, as well as their patients, and if patients

do not care about themselves *and* their physicians, neither party is in the best position, for example, to care about the patient and improve, maintain or restore the health of the patient.

In turn, considering equally the equal interests of patients and physicians protects their mutual well-being in patient-physician relationships. It recognizes and cultivates the synergies described above, for example by promoting in concrete terms the development of integrated patient-physician agreements. These “bridge” the full interests of the patient and physician [11] – rather than require compromise – for the benefit of both. A clinical example of bridging is agreeing to a trial of labor for an expectant mother who favors vaginal birth against the recommendations of her physician for cesarean delivery [12].

Window mirror

Current models of the patient-physician relationship preclude consideration of the equal interests of patients and physicians. These models disregard the moral right and responsibility of physicians and patients to care and be cared about, and the adverse effects of an exclusive focus on the interests of patients. Disagreement with the equal interests of patients and physicians is presumably a result of concern that this principle loses the spotlight on the patient. However, any such concern is mistaken. Consideration of equal interests makes the spotlight larger rather than smaller, illuminating and giving equal focus to the equal interests of patients and physicians so as to sharpen sight of both parties.

Achieving this focus requires a new, more balanced and unified model of the patient-physician relationship. Our model locates this focus in recognition that “to care is to coprovide” [2] for patients *and* physicians according to the capacity and power of each in individual circumstances. This concept of coprovision involves the ability to “see,” and be responsive to, interests of the “other” and “self.” Physicians need to care about the patient

as other and about themselves. Patients have an interest in caring about themselves and the physician as other. Yet, the physician has to enable and encourage the patient to achieve these directions of sight on which basis the patient can share responsibility for coprovision.

The metaphor of the “window mirror” brings this model to life by showing how a balanced focus on self and other makes it possible to see both parties at the same time – and so alternate the focus. If we sit in a lit room and attempt to look out into the dark, the window acts as a mirror whereas a person outside in the dark can look through the window to view its illuminated interior. However, if the light on each side has the same intensity, the glass acts as a window and mirror (Using two partially transparent mirrors achieves the same effect).

The same principles apply to the patient-physician relationship. There is a tendency to think of patients as being in a lit room, while physicians keep the light off. As a result, physicians view patients rather than themselves, and patients are helped to see themselves rather than their physician. Our model therefore emphasizes the need to shower both parties in light so that each can see the other and itself. While specifying a mechanism for increased responsiveness to physician interests, it prevents under-recognition of patients’ legitimate needs; and cannot devalue patient interests without contravening what it means to care. It increases the transparency and directionality of the interaction process – allowing patients to “see out” and physicians to “see in” – so that they can meet their moral rights and responsibilities around mutuality in caring and achieve mutual betterment.

More specifically, the window mirror metaphor makes visible, at the same time, at least four directions of sight: physician to patient; patient to self; physician to self; and patient to physician. The first two directions are the best understood, so we will elaborate the last two.

Patients caring about their physician

The Charter on Medical Professionalism [13] indicates that physicians are healers whose principal role and duty are to respond to patient neediness. Why, then, can and should patients care about their physicians, in support of the above moral imperatives?

First, through self-care, patients also care about a valued other [14], such as a physician, because it is in the interests of physicians, and not merely of patients, for patients to care about themselves. Care about self and care about other are interconnected.

Second, for patients to care about physicians – directly and through self-care [14] – helps patients to avoid an excessive focus on, and find meaning outside of, themselves [15 16]. This can motivate patient behavior [17] and dignifies patients by respecting their situated capacity and responsibility to coproduce care. Physicians are an appropriate focus for patients to care about because physicians and patient-physician relationships are important to patients [18]; and caring *makes* physicians important to patients [19]. In turn, physicians can benefit. For example, being cared about by patients is another source of extrinsic motivation on professional behavior in the midst of pay for performance.

Readers may counter that despite the potential benefits to both parties, seriously ill patients are too physically and emotionally vulnerable to care about physicians – problems exacerbated by asymmetries of information and power in the patient-physician relationship. However, we have already explained that our model does not assume equality of capacity and power between patients and physicians; and we need not be too defensive. At least in non-acute situations, patients may promote their own health or attempt to restore it. Concepts such as the “expert patient” in chronic disease management [20], and “shared decision making” [21], exemplify this shift toward seeing patients as active participants in their own care; all in a social climate in which the notion of patient responsibilities

continues to find growing acceptance [22 23]. Moreover, vulnerable patients can care about others. For example, terminally ill patients have been reported to care about their family caregivers and issues, such as future burdens, affecting them [24]. Worrying about caregivers tempers the benefits noted above but it may be managed through interventions such as education to enhance communication and concordance.

Thus, our basic point stands: patients can care about physicians because care and caregiving are not merely phenomena “of a caregiver perfectly reflecting a patient’s needs but an interaction in which both caregiver and patient care about and for each other” [24]. To argue that sick patients can care only about themselves is to contradict empirical evidence and support a double standard. Perhaps it is not the power differentials but physicians’ “will to power” [25] that really argues against patient reciprocation of caring.

Third, some patients may believe that when patients reciprocate care, or are not free to reciprocate, the physician may exceed for them the ordinary duty of care owed to all patients. If physicians reward some patients only, this is controversial – although not necessarily inappropriate. For example, consider patients who persistently default on appointments without good reason, not caring about the implications for physicians or other staff. Penalties in this situation may be “consistent with justice if they are ‘deserved’ (merit-based view) ... or can fairly guide the allocation of scarce resources or have a reasonable chance of leading to desired patient outcomes (consequentialist view)” [26].

On the basis of these reasons, how might patients care about their physician? One answer is via self-care, and patients are morally obliged to be open, be honest, honor their commitments and disclose relevant information. Most patients can and do respond to cues, such as the use of pause or eye contact, that their physician is under pressure or needs more time or that the visit has come to an end. These patients know what is socially expected and

many can imagine the pressures under which their physician works. Through showing respect and concern, some patients can go further. They can absolve physicians of the need to “rescue” them, not blame physicians for failure that takes place as and when illness progresses, be sensitive to physicians’ own grief and fears, and even “teach ... human dimensions of care” that lead “to healing, for both the patient and the physician” [27].

Physician self-care

Physicians, as noted above, are prone to stress and burnout; and many of them neglect their own health. At least in family medicine, therefore, they have “not only a duty to care for patients but also a duty to care for themselves and their colleagues” [28]. Yet, up to one-third of physicians do not have a regular source of medical care [29]; and according to Avery [30], physician self-care is characterized by 3Ds – delusion, denial and delay – and a 4S approach – “self-investigation, self-diagnosis, self-treatment and self-referral.”

One reason for physicians' work stress is that "in the idealized professional relationship ... physicians' feelings are extraneous." Physician altruism puts care for others before the care of oneself: "patients are intended to be the sole focus of the relationship" [31]. In this context, physician self-interest has acquired a pejorative sense even though, according to Foucault [14], care of the self is required for "the proper practice of freedom in order to know oneself ... form oneself" – and so be able to care about others. In addition, empathy among physicians can make them vulnerable to "compassion fatigue"[10]; physicians' personality profiles can contribute to burnout; and, according to game theory, physicians can try too hard, in repeated interactions with patients, to cooperate for future payoffs [32]. In turn, loss of perceived control over health [29] and lack of self-awareness may best explain physicians' decisions not to seek medical care for themselves [33].

This neglect of work stresses and health needs can produce unintended effects. It can harm physicians' health and be devastating for patients. However, it is because physician self-care can support physician well-being that physicians have been reminded to admit vulnerability and share their emotional lives with patients [34]. Longhurst [33] suggested that physician self-knowledge can come from "accurately perceiving the reflection of one's self in patients ... and examining one's reactions to experiences." Recognition of the "need for physician training in the conscious recognition of their emotions"[31] also underpins proposals for a curriculum and medical model for increasing physician self-awareness[31].

Conclusion

The primacy of patient interests in current models of the patient-physician relationship underscores an unmet need to care better about our physicians and, through logical extension, our patients. We acknowledge that physicians and patients do not have equal

capacity and power to alternate the focus or the provision of care, and we do not wish to burden patients, who may be already vulnerable. However, patients and physicians are morally entitled – and, according to their capacity, are obliged – to care and be cared about. Reciprocation in caring can also be expected to benefit patients and physicians, more so than existing models with their singular, decontextualized focus on patients. Our metaphor of the window mirror describes how physicians and patients can fulfill these justifications for consideration of equal interests. It signifies a new, more egalitarian model whose implementation will require physicians to educate and empower patients to help meet agreed expectations for the coproduction of care as a mutual activity. Doing this can be expected to dignify the moral autonomy of patients and physicians, and co-create an adult-adult relationship conducive to improved and shared health care outcomes.

Table 1: Models of the patient-physician relationship

Model	Description
Patient-centered care	Views health care as “closely congruent with and responsive to patients’ wants, needs and preferences.”[4]
Relationship-centered care	Emphasizes the reciprocal nature of morally valuable relationships that respect the personhood of participants and view affect and emotion as central components [35].
Deliberative care	Describes care in which the physician, as friend or teacher, helps patients to select their own health-related values [36]
Consumerist care	Involves physicians in informing patients about technical issues, which patients use according to their own values to determine the intervention(s) they want the physician to implement [37]
Interpretive care	Engages the physician in elucidating and interpreting patient values and in advising the patient on what interventions realise these values [36]. Decision-making is shared [21].
Paternalistic care	Requires the physician, as guardian, to determine the intervention that is expected best to meet the health needs of assenting patients.

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