The window-mirror: a new model of the patient-physician relationship

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Competing interests: None declared.

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Current idealized models of the patient-physician relationship focus on the care needs and interests of the patient, thus "decentring" the interests of physicians (Textbox 1). A more egalitarian model that sharpens the focus on both parties — without sacrificing patient needs — is required to understand this relationship. We present the "window mirror" model to illuminate the unmet interests of patients and physicians, at least in the context of a continuing relationship, as in family medicine.[1] We describe the theory behind the model (the ethical principle of taking equal interests into equal consideration) and how the model applies in daily medical practice.

The window mirror model

Some models of the physician-patient relationship, such as patient-centred care,[2] acknowledge the importance of issues such as sharing power and responsibility and the practice of "two-person medicine," in which the "physician-as-person" and the patient each continuously influence the other.

However, existing models ignore the principle of equal interests. Care, as it is practised daily, is a relationship-based activity involving reciprocal dependence.[3] It denotes a moral connectedness and respectful attention to our own needs and the needs of others,[4] through which each provides and receives care of mutual benefit.[5]

For physicians and patients, this definition of care precludes a one-sided relationship in which "the patient remains the true focus."[2] It highlights that physicians also need care: they need to be sustained in ways that go beyond payment and the intrinsic value of being entrusted with human lives. Although patients may have greater immediate needs than physicians, both parties share fundamental and equal moral interests in their relationship. These equal interests include dignity, respect and the avoidance of needless suffering, as through self-neglect.

The "window mirror" metaphor brings to life the physician-patient relationship of mutual caring. It shows how a balanced focus on "self" and "other" makes it possible to see both parties at the same time, and to alternate the focus.

If we sit in a lit room and attempt to look out through a window into the dark, the window acts as a mirror. In contrast, a person outside in the dark can look through the window to view the illuminated interior. However, if the light on both sides of the pane has the same intensity, the glass acts as a window *and* as a mirror (Figure 1). One sees oneself looking out and the other person looking in.

The same principles apply to the physician-patient relationship. There is a tendency to think of patients as the subjects, alone in a lit room, while physicians remain outsiders in the shadows. As a result, physicians view the patient rather than themselves, and patients are helped to see themselves but not the physician. The window mirror model emphasizes the need to put the light on so that both can see the other as well as themselves.

As well as increasing responsiveness to the interests of the physician, this model prevents the under-recognition of patients' legitimate needs. It also increases the transparency of the interaction, allowing patients to "see out" and physicians to "see in" — so that they can more easily think about their respective rights and responsibilities.

More specifically, the window mirror 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. We will elaborate the latter two, those currently missing from the models of care listed in Textbox 1.[2,6–9]

Figure 1: The window mirror

Patients caring about their physicians

The Charter on Medical Professionalism[10] indicates that physicians are healers whose principal role and duty are to respond to patient needs. Why, then, can or should patients care about their physicians? We offer two reasons. First, patients can care about physicians by being competent self-carers.[11] Second, caring about physicians — directly, and by being competent self-carers — helps patients to avoid an excessive focus on, and to find meaning outside of, themselves.[12] This motivates patient behaviour[13] and dignifies patients by respecting their capacity and responsibility to co-provide care. Physicians are an appropriate focus for patients to care about because physicians and patient-physician relationships are important to patients,[14] and because caring *makes* physicians important to patients.[15] In turn, the physician who feels valued experiences intrinsic motivation (in contrast to the extrinsic motivation of bonuses).

Physician self-care

Up to one third of physicians do not have a regular source of medical care.[16] According to Rogers,[17] physician self-care is characterized by three Ds — delusion, denial and delay — and the four Ss of self-investigation, self-diagnosis, self-treatment and self-referral. However, beyond the need for physicians to care for themselves outside of the clinical setting is a need for physician self-care in the patient-physician relationship. Exposure to work stresses means that physicians have "not only a duty to care for patients but also a duty to care for themselves and their colleagues."[18]

Physicians' neglect of their own work stresses and health needs can harm their health and that of their patients. Physician altruism puts care for others before the care of oneself: "patients are intended to be the sole focus of the relationship."[19,20] However, as a result of this expectation physicians can become vulnerable to "compassion fatigue," and their workload can contribute to burnout. Although physician self-interest has acquired a pejorative connotation, according to Foucault[11] 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.

Equal consideration of equal interests

There are two justifications for the equal consideration of equal interests in the physician-patient caring relationship: moral rightness and mutual benefit. It is the moral right – and, within the limits of what is reasonable in individual circumstances, the moral responsibility – of physicians and patients to satisfy their equal moral interests through the giving and receiving of care. Right and responsibility exist on the basis of shared "common sense,"[21] a common moral intuition[22] or an "overlapping moral consensus"[23] that patients and physicians have equal dignity and moral value because they are both moral agents.

The second justification depends on the consequences of actions that consider equal interests. Not caring about physicians undermines respect for them[24] and, as noted above, can lead to physician burnout.[20] Patients share the fallout, their interests being integrally connected to what also serves physicians' interests well. In contrast, giving equal consideration to the interests of patients and physicians protects their well-being (and mutual agency), for example by promoting integrated agreements that "bridge" their interests, to the benefit of both.[25]

Why is the window mirror model important?

In the window mirror model the actions of physicians and patients are "interdependent."[26] In contrast to the model of relationship-centred care,[6] equal focus is given to the interdependent and equal moral interests of the patient *and* physician. Caring for the patient and physician is to co-provide care for oneself as well

Textbox 1: Models of the patient-physician relationship

Patient-centred
Views health care as "closely congruent with and responsive to patients' wants, needs and preferences."[2]

Relationship-centred
Emphasizes the reciprocal nature of morally valuable relationships[6] but does not focus equally on the interdependent and equal moral interests of the patient *and* physician.

Deliberative
Describes care in which the physician, as friend or teacher, helps patients to select their own health-related values.[7]

Consumerist
Involves physicians in informing patients about technical issues, which patients use according to their own values to determine the interventions they want the physician to implement.[8]

Interpretive
Engages the physician in elucidating and interpreting patient values and in advising the patient on what interventions realize these values.[7] Decision-making is shared.[9]

Paternalistic
Requires the physician, as guardian, to determine the intervention that is expected to best meet the health needs of assenting patients.

as the other. Co-provision of care values physicians for their own sake and for their ability to care for patients. It also directly benefits patients,[4] enabling them to have no less interest in caring about themselves and their physician. This answers any concern that consideration of equal interests loses the spotlight on the patient. Equal interests instead make the spotlight wider, illuminating the total image.

In addition, the window mirror model does not assume equality of capacity and power between patients and physicians. Instead, it expects each to care about "self" and "other" according to his or her ability to do so. This acknowledges that patients have reduced power (for example, they may be weakened by anxiety and sickness), while physicians typically occupy more powerful roles. However, it also recognizes that, at least in non-acute situations, many "modern patients"[27] can actively promote their own health or attempt to restore it[9] in a climate of growing acceptance of patient responsibilities.[28,29] Even vulnerable patients have the capacity to care about others; for example, terminally ill patients have been shown to care about their family caregivers.[30] Patients *can* care about their physicians: 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.[30]

The window mirror model in daily practice

How can physicians and patients follow the four directions of sight in the window mirror in everyday practice? One way is through adherence to unwritten rules of moral conduct, such as being polite and honest,[31] or to explicit standards of care, including "patient performance standards."[32] These standards may be broad (for example, being on time for appointments or giving notification of lateness or cancellation) or may define the tighter context of the clinical consultation, for example by showing respect for the physician. Regardless, patients and physicians should be open and courteous; honour commitments to each other; and disclose relevant information.

Textbox 2: Approaches to aid learning

Modelling: externalizing the process of care

Physicians can model respectful behaviour that exemplifies how to interact during the consultation. This is important because patients are able to "notice when their physicians seem caring."[36] In turn, they tend to mirror physician behaviour, including nonverbal and appearance cues,[37] although patients may "negotiate" these unspoken "rules" of interaction by modelling their own preferred behaviour. Physicians need to be mindful of their own propensity to reflect patient behaviour[37] and of the feelings aroused by patients. They can use this mindfulness to manage risks of transference and counter-transference and as a "window into both the diagnostic and therapeutic process."[38]

Coaching: guiding

Coaching "suggests" rather than necessarily "shows." It informs the behaviour of the other party without always demonstrating a behaviour to reciprocate. Physicians can coach patients by clarifying their own expectations and by checking for understanding and agreement on what is needed and how to meet the specified needs. These processes must be tailored to the capacity of the individual patient to learn and act in certain ways. Sometimes the education of patients requires physicians to challenge, constructively and sensitively, the beliefs and actions of patients despite their illness and lack of power. Patients can also be enabled to coach physicians, for example by sharing experiential knowledge.

Textbox 3: Applications of learning

Example 1 — Acknowledging and explaining fallibility

An adult patient berates his physician for a long waiting time. The physician can be expected to acknowledge and apologize for the delay before briefly explaining it, as would be characteristic of other models of the patient-physician relationship. However, physicians in the window mirror go further without tipping the balance of care. They gently help the patient to understand how delays, and patients' ability to be mindful and accepting of them, make them feel. The content of this message facilitates physician self-care and coaches patients to care. How the message is given can model how the physician wants to interact with the patient in the future: in an open, honest and sensitive manner that respects the personhood of the patient.

Although not expressed as direct criticism, the physician's statement of expectations and felt stresses introduces a low risk of conflict. However, physicians will convey the message as sensitively as they would themselves wish to be spoken to, because in seeing the patient under stress they also "see" themselves. Meanwhile, in their physician's vulnerability patients see themselves. Their shared experience can strengthen their relationship. Moreover, a relationship in which each party cannot admit to his or her needs is not the kind of strong or mature relationship to which many patients (and physicians) can, and want to, contribute — at least over time. What matters critically is that the visit ends on a positive note. By the end of the visit the patient needs to feel valued and that the care received was equitable, e.g., that the time and attention received was not affected by the delay.

Example 2 — Sharing experiences

A patient expresses anxiety because of workplace stresses, as well as related, unwanted (although not harmful) physical symptoms. The physician in the window mirror will show empathy (a modelling behaviour) by sharing relevant aspects of his own emotional life, such as feelings of professional vulnerability,[39] and by reflecting on the patient's story. The emotions shared will also coach the patient — and support professional needs for learning, since self-knowledge can come from "accurately perceiving the reflection of one's self in patients … and examining one's reactions to experiences."[40]

Example 3 — Anticipating and accommodating dual needs

Supported by past modelling and coaching by the physician, the patient becomes more likely than in other models to become an "equal" partner who can demonstrate regard for the physician as part of an "adult-adult" relationship. The following example illustrates this development. A patient presents with erectile dysfunction since starting fluoxetine. He is also on a beta-blocker. The physician reduces the dosage of the fluoxetine and monitors the patient's hypertension, but the patient also has a third "felt need": he wants to stop the fluoxetine. He understands that asking his physician now to deal with three complex problems would lengthen this visit beyond the "usual" length. So he decides that his own needs and those of the physician may be best served either by not raising this issue until the next visit or by politely raising it now but asking whether a double appointment is possible.

This prescription does not, however, explain *how* to meet rules or standards of care. Even if human caring is innate,[33] learning may be needed to develop, practise, and achieve a caring attitude.[34] Most of this learning takes place outside medicine, with the result that most patients can already respond in socially accepted ways to physician cues during visits. Cues such as the use of pauses or eye contact can indicate that the physician is under pressure or needs more time, or that the visit has come to an end. Respect and care by the patient for the physician's needs would require that the patient act in response to these cues as far as possible. Some patients may also use personal skills that are sensitive to physicians' own grief and fears and absolve physicians of the need to "rescue" the patient.[35]

At other times, patients and physicians need to learn from each other during visits: caring includes helping the other party to learn. Textbox 2 describes two approaches to learning: "modelling" and "coaching."[36–38] Textbox 3 gives three examples that apply both of these learning approaches.[39] In the first two examples, the physician leads in the face of the window mirror, taking physician behaviour as the starting point for patients to learn new ways of caring. In contrast, example 3 describes how patients may come to share the lead by using coaching and modelling to help physicians learn.

Conclusion

The primacy of patient interests in current models of the patient-physician relationship exposes an unmet need to care better about our physicians and, through logical extension, our patients. We acknowledge that physicians and patients do not have an equal capacity or power to alternate the focus or the provision of care, and we do not wish to burden patients, who may be

vulnerable. However, patients and physicians are morally entitled — and, according to their capacity, obliged — to care and be cared about. Reciprocation in caring is likely to benefit both patients and physicians. Our metaphor of the window mirror describes how physicians and patients can consider equal interests equally. It signifies a new, more egalitarian, model whose implementation requires physicians in the first instance, but then also patients, to facilitate mutual learning for the co-provision of care. This dignifies the moral autonomy of patients and physicians and co-creates an adult-adult relationship conducive to improved, shared health care outcomes.

Acknowledgements: The authors are grateful for the anonymous peer reviewer's valuable contribution to this paper. We also thank Victoria Andersen for sitting for Figure 1.

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Citation: Buetow S, Elwyn G. The window mirror: a new model of the patient-physician relationship. *Open Med* 2008;2(1):e20-5.

Published: 8 April 2008