FROM THE EDITORS' DESK

Altruism and Medical Practice

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Altruism, the promotion of another's self-interest at risk or cost to oneself, is at the core of medical practice, tracing its roots all the way back to the Hippocratic Oath. First coined by Auguste Comte, the French positivist philosopher in the early nineteenth century, altruism is also a core component of most religious traditions. While it is often perceived as a selfless virtue, there is some evidence that altruism is not simply an advanced morality that suppresses basic ego-driven urges, but rather is hardwired in our brains, connected to pleasurable activities. Altruism has even been described in some animals, though generally as "reciprocal altruism", that is, helping others with the expectation that they will in turn help you. Vampire bats will share their blood meal with another bat even though they risk death if they go without a meal for a few days. Primate grooming behavior is another, less gruesome example.

Lately, however, it seems that altruism has gone out of fashion, at least among humans. Over the past year, the United States has failed to adequately respond to the plight of desperate refugees from the Middle East, charitable giving is forecast to decline in 2016 for the first time in almost a decade, and we elected a fantastically wealthy president who is proud to have paid as little income tax as he could get away with. Some have even argued that altruism is on the decline in medical practice.[1]

In this issue of *JGIM*, Riggs et al.[2] report on a fascinating study in which they examined whether appeals to altruism would reduce patient requests for overused medical services identified in the Choosing Wisely campaign. Choosing Wisely aims to improve health care quality and control costs by limiting the use of common but overused medical tests and treatments. In this study, Riggs et al. presented study participants with three hypothetical vignettes (antibiotics for acute sinusitis, imaging for acute low back pain, and an annual physical exam in a healthy patient) and asked them to imagine that they were seeing a physician for a common health problem (acute sinusitis, low back pain, or a general check-up). In the control vignette, the physician's rationale for recommending against the service was framed as providing minimal benefit and potential for harm (e.g. in the sinusitis vignette, they were asked to imagine that they had symptoms of sinusitis and that antibiotics were unlikely to have a benefit and might cause stomach problems). In the altruism version of the same vignette, the rationale for not being prescribed antibiotics included an additional reason: that forgoing antibiotics would provide a potential benefit to others (e.g. not taking antibiotics would help prevent antibiotic resistance in the community). The authors also examined the effect of altruistic appeals on physician ratings by the participants. The hypothetical appeals to altruism had no effect on participants' decision-making regarding receipt of unnecessary medical tests. In addition, the vignettes that included appeals to altruism resulted in more negative physician ratings.

While some research has found that patient willingness to obtain vaccines or donate blood is motivated at least in part by altruism, there is not much reason for optimism that this approach will be a successful strategy for improving health care value, especially in the current social and political climate. And the scant research on physician attitudes in this domain tells a similar story. For example, in an earlier study, Metlay et al.[3] asked physicians to what extent their prescribing of antibiotics for community-acquired pneumonia was informed by concerns of creating resistance for other patients, and found that physicians rated antibiotic resistance lowest among seven determinants of their choices. We clearly have more work to do to educate patients that more care, i.e. more tests and treatments, is not synonymous with better care, and that physicians may demonstrate their care, and competence, by doing less, not more.

Many physicians would assert that they were motivated to become doctors in part because of altruism—what is sometimes framed as a "calling". For some, this desire to help may be overwhelmed by the day-to-day demands of the work. Interestingly, the concept of "pathological altruism", i.e. altruism or empathy taken to an extreme, has been hypothesized to contribute to burnout and depression among health care providers.[4] In fact, over the past few years there have been alarming reports of high rates of burnout among practicing clinicians and trainees. As a result, more attention has been focused on the importance of physician well-being. In this issue of *JGIM*, Tak et al.[5] report on a survey of 2000 US physicians that examined the association of intrinsic motivators with career and life satisfaction as well as clinical commitment. As the authors point out, to date, most studies of physician well-being have

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focused on extrinsic motivators (e.g. work hours, income, and control over work) and much less on intrinsic motivation (e.g. medicine as a calling, meaningful relationships with patients). The majority said that, for them, medical practice was a "calling", and a sense of calling was strongly associated with a commitment to direct patient care. Extrinsic motivators such as income and other work-related factors were not strongly associated with measures of well-being. This study and others will help leaders and policymakers identify the factors that support physician, as well as patient and organizational, well-being.

Also in this issue, Pham-Kanter et al.[6] report on a study that focused national attention on public awareness of and exposure to physicians who receive industry payments. The authors found that while patient contact with physicians who received industry payments was high, only 12% of patients were aware that such payment information was publicly available, and only 5% knew whether their own doctor had received payments. For some patients, whether their physician receives payments from industry may be irrelevant; for others, it may influence their choice of physicians, or they may be concerned that these payments have the potential to impact clinical decision-making.

For some physicians, altruism and a sense of calling are at the core of their motivation to practice medicine; others are motivated by more tangible rewards. Whatever the motivation, it is important that we take the time to reflect on our professional and personal values and strive to align our work with those values.

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