

EDITORIAL AND COMMENT

Appealing to Altruism May Not Work, But Don't Give Up Hope

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J Gen Intern Med 32(7):721–2

DOI: 10.1007/s11606-017-4044-8

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“**R**uin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons,” wrote biology professor Garrett Hardin in 1968.¹ “The Tragedy of the Commons” presents an eyes-wide-open, cynical view of individuals’ inability to sacrifice their own interests to protect shared resources.

Recent efforts related to health care value have largely sought to define value,² articulate the motivations for patients and clinicians,³ and identify obvious areas of overuse and low-value care.⁴ These are critical foundational steps, but have thus far led to limited impact in actually reducing overuse.

In this issue, Riggs and colleagues provide what may be read by many as sobering evidence to support Hardin’s thesis.⁵ This experimental survey asked an online panel of adults to read hypothetical scenarios where physicians recommend against medical services that may be commonly overused: antibiotics for acute sinusitis, imaging for acute low back pain, and annual exams for healthy adults. In one version of the vignettes, the physician explains the minimal potential benefit and risks of harm of the proposed intervention. In the other version, the physician adds a line or two that describes potential benefit to others by forgoing that service. The authors hypothesized that adding these altruistic appeals would reduce requests for these overused health services and would not affect physician ratings. That’s not what happened.

Approximately 40% of adults in both groups still wanted antibiotics, 45% wanted imaging, and 80% wanted an annual exam. It is notable that 43% of participants reported having previously received antibiotics for acute sinusitis and 31% imaging for back pain—a snapshot of the prevalence of questionable medical services.

The real eye-opener is that vignettes appealing to altruism were associated with lower ratings of the physician in the acute sinusitis and back pain scenarios. Perhaps this is an artifact of the study design: in a survey vignette, a faceless doctor talking about the benefits to others might raise suspicions about underlying motivations. On the other hand, the findings ring true with our experience trying to communicate similar concepts with patients and the public.

HUMAN ILLNESS BEHAVIOR

People don’t seek care for symptoms alone. People seek care for symptoms plus concern.

Humans are wired to “prepare for the worst” when symptoms become a concern. Psychologists refer to this as catastrophic thinking. Catastrophic thinking is one of the strongest correlates of symptom intensity and functional limitations, typically much stronger than the degree of pathophysiology.^{6,7} Stress and distress make catastrophic thinking worse.

The roots of catastrophic thinking are cognitive fusion (the degree to which thoughts are perceived as facts) and negative affectivity (the tendency to interpret things negatively). People seeking care sometimes exhibit less flexibility in their thinking (thoughts are facts) and are often prone to see the worst in symptoms, circumstances, and individuals.⁸

Current best evidence and expert advice often run counter to our first impressions, gut feelings, or intuition. A person seeking care comes with a theory about what’s wrong and often has most of their hope pinned on a specific approach to fix it—for instance, “My back is damaged” and “my only hope is to do an MRI, find the damage, and fix it.” Expert advice that contradicts a person’s “thought as fact” and “only hope” scenario may be an affront. More than a disagreement, medical disputation of this sort is an assault on the patient’s worldview, and perhaps her future.

Any attempts to try to direct a patient—to try to talk them into or out of something—may seem arrogant, dismissive, and belittling. A confident dispensing with what a patient may see as their only hope may feel hurtful. Some people may want to “strike back” with mean words, a bad review, a complaint, or even a lawsuit.

THE SCIENCE OF EFFECTIVE COMMUNICATION

There is a fair amount of evidence that directing approaches, whether appealing to evidence or altruism, are not as effective as guiding approaches—communication strategies that help people ensure that their preferences are consistent with their values and not based on misconceptions.

The key elements are compassion and empathy.⁹ It starts with taking a genuine interest in people. Try to understand what matters to patients and share their goals rather than confronting their initial thoughts about what to do. Begin with active, empathetic listening; get to know a few things that

make that person special; summarize and legitimize their concerns; then ask permission to move on to the examination.

Physicians can convey their expertise concisely, using non-technical language, in a way planned to optimize hope, pausing for questions between points. For instance, “Would you like to hear more about back pain? 1) Low back pain happens to healthy people doing healthy things. 2) It can last days, weeks, or months, then passes. 3) Movers heal faster. You want to be a mover. Keep to your usual routine.” If a person says something like, “I have a high threshold for pain. It feels like something’s wrong,” it is not usually helpful to cite data or even to elaborate on probabilities. An appeal to evidence may sound like points in a debate. That may be how the appeal to altruism comes off as well. It may be better to simply express empathy for how counterintuitive it is that pain this bad is nearly always something transient and benign.

Using practiced scripts for common problems, we can convey our expertise in just a minute or two. That leaves plenty of time to address each individual’s specific concerns. One simple tip is to replace the closing phrase, “Do you have any questions?” with the open-ended “What questions do you have?” “Tell me your questions” or “How does that fit with what you were thinking?” People seeking care always have questions, and we should elicit and address them: again, with empathy not with evidence.

We can learn effective communication techniques for high-value care and develop methods to teach, disseminate, and practice them. This may be analogous to recent progress in addressing communication around end-of-life issues.¹⁰ Over the last decade, palliative care experts have defined straightforward, reassuring common phrases, relying heavily on questions, to use during end-of-life conversations.¹⁰ These strategies are now taught in many medical schools and training programs, as well as through a series of communication courses aimed at practicing physicians, such as Oncotalk for oncologists.

CONCLUSION

Our success in delivering on the promises of high-value care will depend on our ability to effectively communicate with patients and the public. The finding that altruistic appeals to patients may not convince them to change their perspective is

not as surprising as it may first seem on the surface. Patients who seek care have natural concerns that shape their responses. Directing approaches that appeal to evidence or altruism are unlikely to be as effective as guiding approaches. The study by Riggs and colleagues is asking the right questions. We should now study different potential solutions to help us all learn how to effectively engage patients in reducing medical overuse.

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Compliance with Ethical Standards:

Conflict of Interest: None relevant to this manuscript. Outside of the submitted work, Dr. Christopher Moriates receives royalties from McGraw-Hill for the textbook *Understanding Value-Based Healthcare*.

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