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Balancing altruism and self-interest: GP and patient implications

Research Article

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Abstract: This paper explores how general practitioners (GPs) address potentially opposing motivations stemming from being altruistic and self-interested, and the implications for patients and GPs. The author finds that GPs address dual goals of patient care and profit generation. This can be challenging, while professional values (altruism) encourage a patient focus, business realities (self-interest) mandate other priorities. Viewing clinicians as altruistic in isolation of business needs is unrealistic, as is the notion that profit is the dominant motivation. A blending of interests occurs, pursuing reasonable self-interest, patients' best interests are ultimately met. GPs need a profit focus to sustain/improve the practice, benefitting patients through continued availability and capacity for enhancement. Therefore, it is argued that GPs behave in a manner that is 'part altruistic, part self-interested' and mutually beneficial. These insights should be considered in designing incentive systems for GPs, raising compelling questions about contemporary understanding of the nature of professionals.

Keywords: *altruism; general practice; professions; qualitative research; self-interest*

INTRODUCTION

The word 'profession' has its foundation in the Latin word 'professio', which essentially means the declaration or swearing of an oath. This reflects the traditional vocational nature of the professional, whose specialised work is built upon extensive and deep training, knowledge, wisdom and experience that is applied towards serving the critical needs of people and delivering quality outcomes more so than personal economic gain (Cogan, 1953; Freidson, 2001). A recurring feature of professions is the existence of a code of ethics (Hall, 1968), as members function from a position of shared values (Goode, 1957), with a 'primary orientation to the community interest rather than to individual self-interest' (Barber, 1963: 672) as a traditional core attribute (Freidson, 1988). Indeed, Freidson (2001: 218) goes as far as to state that 'There can be no ethical justification for professionals who place personal gain above the obligation to do good work for all who need it, even at the expense of some potential income'. Thus, the professional's motivation is held to be principally of an intrinsic nature, whereby tasks are performed for their own sake and their own inherent satisfactions (Bénabou and Tirole, 2003; Ryan and Deci, 2000).

However, Freidson (1988) contends that evidence of a strong service emphasis being widespread among professionals is lacking, questioning then how relevant this is in our understanding of their nature. Instead, he suggests that while such an orientation may be present, so also is an inclination to seek and value financial reward as they co-exist within the individual. The importance of organisational goals to professionals in what might be viewed as the more 'commercial' professions – such as engineers (Derber, 1983), lawyers (Gunz and Gunz, 2007) and accountants (Shafer, 2002) – has been previously established, which may conflict with professional goals (Aranya and Ferris, 1984; Kippist and Fitzgerald, 2009). Indeed, Spence and Carter's recent (2014) study of senior professionals in large auditing firms found that those who placed greater emphasis on commercial aspects over technical aspects advanced further up the organisational hierarchy. The authors conclude that this may be somewhat inconsistent with their firm's mandate to serve the broader public interest.

Other commentators, such as Relman (2007), argue that medical professionals have also moved further away from prioritising the interests of patients and are giving increased emphasis to profit and commercialisation

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(Mechanic, 1996; Perry, 2010). Jones and Green (2006), with specific reference to general practitioners (GPs), note how their professional nature has seemingly been reframed to de-emphasise the vocational imperative with other interests, such as quality of life becoming increasingly important. In this regard, the professional may be placing more value on extrinsic motivators, where the activity is performed to deliver a separate outcome such as a contingent reward (Bénabou and Tirole, 2003; Ryan and Deci, 2000). Such rewards can potentially 'crowd out' more intrinsic motivations (Frey and Jegen, 2001) and may have negative long-term implications (Bénabou and Tirole, 2003), as while they address lower-order physiological needs, they do not encourage one to self-actualise and grow (Maslow, 1954). Thus, the modern professional may have somewhat moved away from the more traditionally espoused values and motivations – such as the pre-eminence of the service recipient's needs – towards more contemporary needs, including those geared towards the express benefit of the professionals themselves.

RESEARCH MOTIVATION AND GOAL

In being a professional, one is expected to demonstrate professionalism, which is central to being a good doctor (Medical Council, 2009; Royal College of Physicians [RCP], 2005). Van de Camp et al. (2004) indicate that, of the elements commonly associated with professionalism, altruism is referenced most often in the medical literature and is one of the hallmarks of professions (Hodson and Sullivan, 2012). Thus, altruism is internationally viewed as a core value (Connell, 2009; RCP, 2005; Swick, 2000) and is important to the clinical profession (McGaghie et al., 2002; Wicks et al., 2011).

However, Descombes notes (2002: 159) that 'part of the mythology of medicine is that it stands above such base interests as money', as it is both a business and a profession wherein the service providers have financial interests and financial obligations to satisfy (Heller, 2012). Consequently, doctors may be 'faced with a moral and ethical conflict between the needs of the patient and economic imperatives' (Irish Medical Organisation [IMO], 2012: 3), with limited consideration in the literature as to how they react when financial incentives threaten their professional values (Young et al., 2012). As Heller (2012) notes, 'pay for performance' mechanisms may increase the quality of care and reduce overall costs but may also undermine professional discretion. The lack of clarity as to whether clinical professionals should, or do, adopt one stance over the other – altruism or self-interest – is central here.

GPs represent a particularly interesting professional group to study in terms of altruism and self-interest as they are subjected to both motivations. By virtue of being a medical professional, patients' needs and achieving the best health outcomes are obvious intrinsic motivators, and this perspective is expected of the GP by the wider public. In this respect, they are a professional, but perceived as less 'commercial' than some other professions. However, there is another important reality, which is that of the GP as a business owner, employer or employee, who is dependent on the income generated from patients for their livelihood. This can act as an extrinsic motivator to prioritise the interests of the self or the practice. Thus, what best serves the patient might not directly best serve the GP in a business/personal capacity, creating a possible tension between both of these facets (Gillies et al., 2009; Wainwright et al., 2014).

This paper seeks to understand how GPs address these potentially opposing motivations in the context of limited existing (Hausman and Le Grand, 1999; Hennig-Schmidt and Wiesen, 2014) and contradictory evidence. Given that, in Ireland and internationally, 'a number of recent developments suggest that the issue of financial incentives is garnering more attention from researchers and policymakers' (Brick et al., 2012: 294; also Jain and Cassel, 2010) and there remains an ongoing need to consider how GPs are remunerated, this study is timely. Thus, the research question in this paper is as follows:

How do GPs address potentially opposing motivations from being altruistic and self-interested, and what are the implications of this for both patient and GP?

LITERATURE REVIEW

Perspectives on altruism

Piliavin and Charng (1990: 30) define altruism as 'behavior costly to the actor involving other regarding sentiments; if an act appears to be motivated mainly out of a consideration of another's needs rather than one's own, we call it altruistic'. Wakefield (1993: 417) refines this definition by contending that a cost need not necessarily arise: 'a

motivational state with the ultimate goal of increasing another's welfare'. Lin-Healy and Small (2013) indicate that where personal benefit for the giver is involved, the degree of perceived altruism is adversely affected. Indeed, Le Grand (1997) suggests that altruists may reduce/cease their helping behaviour if compensation eliminates the personal sacrifice that gives rise to satisfaction, as external incentives can lower intrinsic motivation (Batson and Powell, 2003; Green, 2014; Jain and Cassel, 2010; Tang et al., 2008). Although Wakefield (1993) concedes that it can be more challenging to experience altruism when monetary rewards are involved, he does not accept that it is impossible as motives can be mixed (Batson and Powell, 2003; Di Norcia and Tigner, 2000; Wicks, 1995). Altruism need not exclude self-concern or one is veering towards martyrdom (Maier and Shibles, 2011).

Thus, although altruism appears to entail a benefit to others as the primary motivation, it is less clear as to whether costs/gains for the giver are necessary/acceptable for the act to remain altruistic. For doctors, who receive payment and subscribe to professional ideals, this may be challenging: 'Profit is not immoral, nor is it professionally unethical ... Yet doctors have traditionally sought to hide this motivation for practice' (Descombes, 2002: 165). Therefore, it is important to examine both motivations before addressing how they interact.

Altruistic tendencies: meeting the needs of patients

Vera and Hucke (2009: 80) suggest that 'there will be hardly any physicians who attach more importance to economic goals than to quality of care', being intrinsically motivated to provide high-quality care (Green, 2014). Indeed, Pellegrino (1987) argues that altruistic behaviour by doctors is an obligation. Thus, the primacy of the patients and their interests is acknowledged (Mechanic, 1977; Medical Council, 2009; Pellegrino, 1999; Swick, 2000), and money should not be the focus (Hoffenberg, 1987; Hoogland and Jochemsen, 2000).

McDonald et al. (2010) accept that money is a motivator for GPs, but the notion that this purely drives them is disputed; even though professionals seek opportunities to generate income, this is in conjunction with professional values (Locock et al., 2004). This aligns with the view of Heller (2012), who argues that financial incentives for doctors are acceptable, but as 'by-products' of doing what is expected of them. Spoor and Munro (2003) found that GPs, who had the choice as to which secondary care provider to refer patients to, were not primarily influenced by price even though referring to cheaper providers meant more residual funds for reinvestment in their own practice. In this regard, financial incentives did not appear to have much bearing on their patient-related decisions. Gartland and Carroll's (2004) research indicates that capitation payments were linked to higher spending levels by doctors. While savings were achieved in office costs, increased amounts on administrative staff, information services and nurses offset this. This suggests that doctors need not engage in 'profiteering' but, rather, can utilise the resources generated to benefit patients (Hausman and Le Grand, 1999) through service enhancement.

McDonald et al. (2007) found little evidence that financial incentives for GPs interfered with their professional values, noting that the rewarded indicators were consistent with what they held to be appropriate. According to McDonald et al. (2013), a lack of incentives or targets does not necessarily equate to a lack of care. Brick et al. (2012), Hausman and Le Grand (1999), Nolan (2007) and Tussing and Wojtowycz (1986) note that factors such as guilt, negative patient reactions (including leaving the practice) and relations, genuine concern, protocols, standards and ethical codes, as well as the perceptions of others, can limit self-interest. A 'moral motivation' is present (Marshall and Harrison, 2005) in that economic factors are just one of many inputs to a clinical decision, including patient health benefits (Cheragi-Sohi, 2011; Hausman and Le Grand, 1999; Hoffenberg, 1987).

Therefore, incentives are most likely to be effective when they are aligned with the GP's professional values (Campbell et al., 2007; McDonald and Roland, 2009; Young et al., 2012). However, where these values are already consistent with the best interests of patients, this may reduce the significance of the incentives themselves (Sheaff et al., 2012). Reflecting this, O'Donnell et al. (2011) have found that while patient care improved under an incentivised set-up, so also was care for a further un-incentivised condition, while Kontopantelis et al. (2014) identify that removing incentives did not result in a decrease in performance.

Doctor self-interest: income-seeking behaviour

Literature also highlights how income can be an important motivation for action. Commercial interests are relevant as professionals are generally responsive to financial incentives (Young et al., 2012), valuing income and prestige. Whynes et al. (1999) found that GPs reacted in a predictably positive way towards financial incentives. More than three-quarters of their sample felt that the financial rewards from general practice were inadequate and that there was a conflict between incentives and professional behaviour, while two-thirds believed that finance had become of greater importance than patients. Thus, GPs can demonstrate self-interest.

As evidence, Pockney et al. (2004) identified GPs making extensive use of a surgical procedure that, although more profitable for them, is no more effective than cheaper alternatives. Walley et al. (2000) found that financial incentives associated with prescribing can encourage changes in GP behaviours, while the use of 'fee-for-service' has the potential to induce demand through incentivising repeat visits and over-provision of care (Brick et al., 2012; Godager and Wiesen, 2011; Gosden et al., 2001; Green, 2014). Croxson et al. (2001) identified that fundholding[1] GPs availed of 'unintended incentives' by increasing hospital admission activities before fundholding and decreasing them afterwards, providing them with greater financial resources.

Under the UK Quality and Outcomes Framework[2] (QOF), McDonald et al. (2010) note a risk that practices may prioritise activities that are profitable but give rise to relatively low population health gains. In addition, the QOF permits the exclusion of certain patients from target scores, helping to improve attainment. This may lead to negative outcomes in other parts of the practice (McElduff et al., 2004; Mangin and Toop, 2007; Roland et al., 2006) where incentives do not apply, as well as for the excluded patients themselves. O'Donnell et al. (2011) highlight that, while finding no evidence of un-incentivised conditions being actively neglected, practices had limited slack to fully address these because of time devoted to incentivised areas. The acceptance of targets can also change the way that patients are viewed; instead of patient concerns driving consultations, their contribution to achieving incentivised quotas can be influential (McDonald and Roland, 2009; McDonald et al., 2008).

Seeking balance: a duality of interests

Evidence from previous literature highlights that doctors are faced with conflicting motivations (Jain and Cassel, 2010). However, interplay can exist (Wicks, 1995) and lines may be blurred (Maitland, 2002); as Batson and Powell (2003: 474) note, 'the motivation could be altruistic, egoistic, or both'. Thus, GPs confronted by incentives need to consider the consequences of clinical decisions to ensure that patient interests are preserved (Marshall and Harrison, 2005; Smith and Morrissey, 1994), as – in addition to other potential outcomes – the patient can go elsewhere (Hausman and Le Grand, 1999), which may be commercially damaging. By serving the needs of patients, financial success should follow (Wicks, 1995).

This duality of interests is consistent with the findings of Mechanic (1975), who notes that doctors who received a fee-per-service tended to work longer to accommodate higher demand, increasing both service availability and income, as opposed to those in prepaid practice, who could seek to address extra demand by processing patients faster. Similarly, Le Grand (1997) indicates that incentivised reinvestment of savings in services by GPs benefits both doctor and patient. Thus, the pursuit of self-interest can be in the interests of the patient, whereby an improved service is delivered: 'motivation based on self-interest will do a better job of providing benefits to others than will motivations based on altruism' (Rubin, 2009: 408). In this context, a degree of self-interest – as opposed to selfishness – may actually be a virtue and a 'precondition of altruism' (Maitland, 2002: 6).

Downie (1986a, 1986b) argues that doctors need to make a profit to survive without being swayed by undue self-interest; this does not prevent them from performing altruistic acts within their role, but simply fulfilling the paid professional role does not constitute altruism and there is no obligation to be altruistic. Gillon counters (1986a: 59) that doctors have a moral duty to their patients beyond any financial arrangement such that, while self-interest is present, their obligation 'is at least in part altruistic in that it is self-imposed by the medical profession not to benefit themselves but to benefit their patients'. Thus, although financial returns constitute a motivating factor, Gillon (1986b: 172) contends that this is only partial and balanced by altruism (being 'for the benefit of others') as a further motivation, which does not exclude the possibility of gain. Consistent with the theories of Jensen (1994) and Wicks (1995), the presence of self-interest does not mean that people lack altruistic motives in the same way that being altruistic does not entail merely doing the bidding of others with no regard for one's own preferences and benefit. Rather, as Maier and Shibles (2011: 241) suggest, some balance is needed because 'positive altruism and positive egoism are always desirable'.

This suggests that a strict view of altruism is difficult to sustain in modern practice (Wicks, 1995) and can even be harmful (Maitland, 2002). It may be that some form of moderation is a more appropriate expectation such that benefiting others is not utter self-sacrifice (Bishop and Rees, 2007; RCP, 2005) because financial factors affect clinical decisions (Fisher and Best, 1995; Godager and Wiesen, 2011). This indicates a context that more closely reflects the simultaneous significance of patients and business (Perry, 2010; Roche and Kelliher, 2014; Wicks, 1995), such that 'reasonable' and appropriate self-interest (Heller, 2012; Maitland, 2002) comprise an achievable outcome. Thus, while they may operate between two value orientations, these need not be divergent (Kulshreshtha, 2005), incompatible (Birnik and Billsberry, 2008) or polar opposites but rather 'diametrically intertwined' (Maier and Shibles, 2011: 230).

Therefore, in summary, the literature identifies that the traditional orientation of professionals has been to place the needs of others ahead of their own, motivated intrinsically by the act rather than any personal benefit. However, this appears to be changing somewhat as commercialism and profit increase in significance for professionals, representing extrinsic motivators. One may then question the continuing relevance of the established concept of altruism for the medical professional and whether this is being replaced by self-interest. A review of the existing evidence is inconclusive, because although altruistic behaviours are observable, so also are behaviours more in tune with income or reward maximisation. This may suggest the need to refine our understanding of both concepts when applied practically, with perhaps some middle ground or moderated orientation a more realistic expectation that has implications for professionals and their clients.

CONTEXT

The context for this study is the GP. In Ireland, GPs are a key element of the primary care sector (Department of Health, 2012; Layte and Nolan, 2009). Patients either pay the GP's practice directly for the service ('private patients') or the cost is covered by the state because of undue hardship ('public patients') and in certain other cases (e.g. Maternity and Infant Care Scheme), with most practices providing services to both private and public patients. For public patients, GPs receive a funding mix of mostly capitation and some 'fee-for-service' payments. These remuneration structures, as highlighted in the 'Literature review' section, have their pros and cons depending on the orientations of the GPs themselves and remain a controversial and unresolved issue. GPs may operate in the following modes: as sole traders, in partnerships or groups, as owners or as employees of other GPs. In this regard, they operate within predominantly GP-owned and controlled, independent and income-seeking small businesses. An implication of this structure is that GPs directly and indirectly have both professional (patients) and commercial responsibilities (practices).

METHOD

A qualitative approach was utilised in this study. Semi-structured interviews were conducted with 35 (19 male, 16 female) Irish GPs, broken into subgroups. This sample consisted of various categories of owners (partners and sole owners, totalling 21) and employed (assistant, sessional and locum, totalling 14) GPs, to provide diverse perspectives. These categories represent the predominant types of GPs working within the Irish system and help to ensure that the data is not narrowly focussed on just one type. Participants were purposively drawn from different practices nationally (urban/rural, small/large), ensuring that findings are not narrowly focussed. The sizes of these practices varied from a low of two staff members to a high of more than 35 staff (average size: 10 staff), highlighting their micro/small business[3] nature. Interviews averaged approximately 1 hour, and ethical approval was obtained for the study from the Dublin City University Research Ethics Committee. Data saturation (Guest et al., 2006; Suter, 2012) was assessed during the study and was achieved by virtue of the fact that no new information was generated from the final interview in each subgroup.

After piloting the protocol, interviews were conducted primarily by telephone and were fully recorded and transcribed, accompanied by note-taking of aspects that appeared interesting or worthy of subsequent follow-up (Lee, 1999; Patton, 1990). Informed consent was obtained from all individual participants included in the study. Interviewees were offered copies of their individual transcripts to review, and changes were made where requested. Questions asked in the interviews addressed a range of topics, including roles, staff interactions, management/business and dealing with role conflict. Some secondary sources were used to supplement and corroborate aspects of the interviews where possible (Sekaran and Bougie, 2010), such as practice websites and newspaper articles. Interviews are of particular benefit when the researcher wishes to study complex areas in depth (Kumar, 2005) and investigate activities that cannot be directly observed (Taylor and Bogdan, 1998), as well as when researchers seek to explore an individual's knowledge, understanding, meanings and interpretations (King, 1994; Mason, 1996). These were of considerable importance in the current study.

A qualitative data analysis package (NVivo) was utilised to assist with data management and coding. Thematic analysis (Braun and Clarke, 2006) was used to extract key themes from anonymised transcripts over a multi-phase analytical process (see Figure 1 for a diagrammatic summary of the phases of data analysis and the key outputs produced in the overall study). Codes were derived from both theory (literature) and data. Each identified

code was written up, as the researcher sought to capture the essence of the 'story' by summarising what the data was saying and meaning, illustrating this with relevant quotes (Braun and Clarke, 2006; Creswell, 1998). A further editing exercise grouped codes within their underlying themes to produce a 'findings document' for the overall research. The following findings represent a subset of this document, as relevant to the current paper, which stem from questions addressed to participants surrounding their experiences of conflicts between their clinical and managerial/administrative roles, as well as the impacts of such conflicts on the participants. Table 1 outlines the key codes that arose from these questions and that were used in extracting the findings in the current paper.

Figure 1. Diagram of the phases of data analysis and key outputs produced

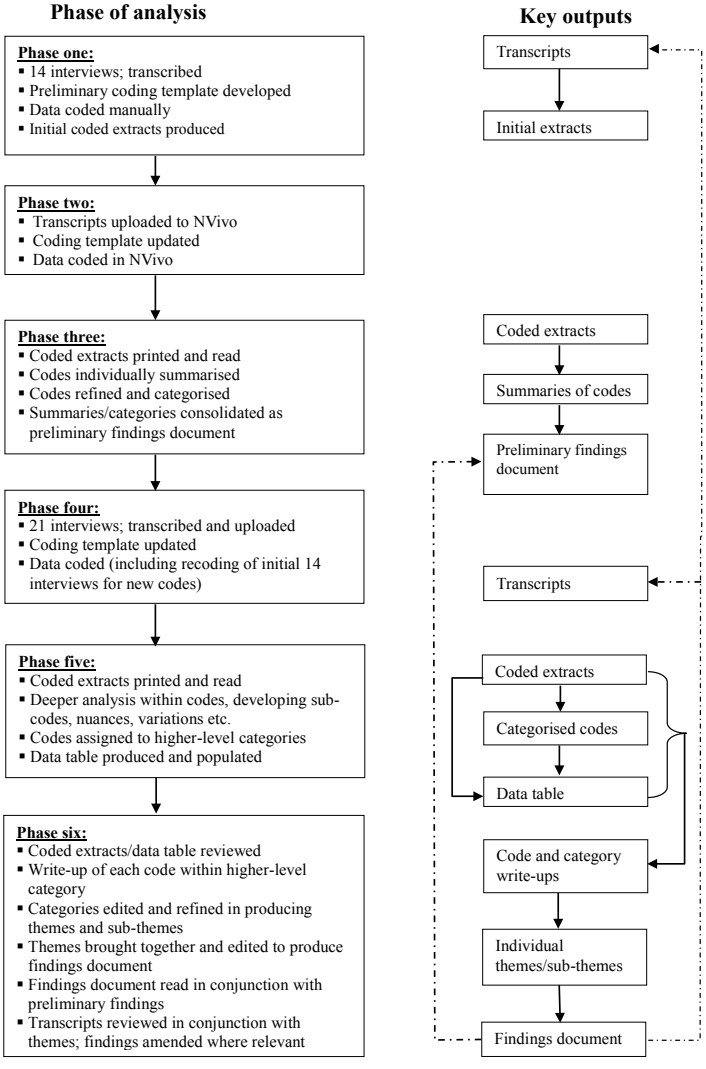

Table 1. Key analytical codes used

Reducing costs	Clinic-driven income
Income important	Vocational aspects
Services with income in mind	Not financially driven
Money not motivation	Difficult times
Money to sustain family	Being financially driven
Is a business	Need business focus
Patient first	Balance
Priorities flexible	Payment

FINDINGS

Profiting from serving the patient

The conflict between being in business and caring for patients was apparent. GPs recognised that they are dealing with something sensitive and personal from the patient perspective: 'Money isn't really what we are all about; at the end of the day, we are all making a comfortable living on it' (GP 33 [Employed, E]). However, there was also the wider concern surrounding the continuance of the practice and their own livelihood: 'You can't be a clinician and not have any money coming in the door' (GP 23 [E]). This can create an internal dilemma:

> It's a business and you have to make a profit, but it's also a service and I suppose those can be in conflict. One can be stronger than the other, depending on the philosophy of the practice. (GP 6 [Owner, O])

GPs may attempt to generate income from other sources that neither directly affect the patient financially nor hamper service delivery. In GP 32's practice, where they received government-funded General Medical Services (GMS) payments for public patients, which more than covered the cost of a service, this presented an opportunity to reinvest in others:

> (U)ntil the financial emergency legislation came in there ... [during the 2008–10 global financial crisis], a lot of GMS practices were able to put in extra services for their patients, certainly their GMS patients, because they were maybe paid more for one thing and paid maybe nothing at all for another thing, but in general, it worked because the patient got what they needed somehow, it balanced out. That is happening less now. (GP 32 [E])

Interviewees suggested that too much of a financial emphasis can adversely affect quality of service and patient interaction, and this makes them uncomfortable: 'You have someone who brings their kid in and charge them 50 quid to tell them to keep taking Calpol, they're not going to be interested in seeing you again – they'll want an antibiotic. Desperate way to practice' (GP 18 [O]). However, the lack of any emphasis on money is also an issue, which can put a strain on practice viability: '(T)he main GP, I'd say half of his neighbours don't pay. So, they were never financially motivated, but now things are tight and there's panic' (GP 23 [E]).

GP 10 articulated the challenge of balancing business and caring when discussing the dilemma they face in prioritising paying or non-paying patients, as they seek to balance multiple issues of a clinical and financial (short- and long-term) nature:

> One of the reasons we're here is profitability, so should I bring this patient back for another appointment, they're a medical card [GMS] patient ... we get paid a capitation which means if I see them less, they chew up less resources, if I see them more, they chew up more resources and therefore our profit drops. That tension between ... even from a purely business point of view. If you send out the message that we don't want to see you, then people are not going to be there when you need them so you won't have any business at all. So there is a tension between doing it right for the person and what is financially advantageous to the practice. That's always there. (GP 10 [O])

Service decisions – balancing gains

The provision of patient services is affected by the business realities that practices face, with falling incomes and funding being withdrawn. GPs need to consider the impact of offering/withdrawing services on patients, as well as the costs/benefits to the practice:

> We had huge bills for postage. We used to ring up and make appointments for people and send them out their referral letter and their appointment. She [practice manager] said to forget that, we're not going to do that anymore. Give them the number and let them ring and make the appointment themselves because if we were ringing, sometimes it would be three phone calls to make one appointment ... They were the kind of things that actually made the difference in us making a profit. (GP 3 [O])

GP 22 (E) noted that a key decision for their practice is whether to continue to run a clinic 'that is not making money but that is very good for patients'. They described this as an 'ethical' decision, which resulted in its continuation 'at the moment while they can still afford to do that'. Thus, the value of this service on both sides is actively considered, and remains in the balance. GP 32 (E) indicated that, in their practice, the prospect of introducing enhanced income-generating services had been considered but not pursued because time was not available to provide this in addition to standard services. This would have required giving up a guaranteed income source for one that was less assured.

GP 35 (E) introduced a new service to their practice, explaining that it was to do with 'patient service but there is a financial and a personal element to that as well'. They noted that one of the core attractions was that the service would not only bring in new patients, but their families as well, increasing the patient base. The GP acknowledged that no costing was prepared, and research was limited to asking patients in the surgery block whether they would be interested, but also commented 'I hope this doesn't sound very cold and calculating'. This suggests that patient needs were a factor in the decision, but that practice gains are also considered.

The payment 'problem': creating distance

An issue highlighted in some interviews concerned payment for services. Some non-owner GPs struggled with the notion of taking cash from patients. This created a degree of discomfort: 'I don't like people actually just handing money over to me; I don't like the way that feels' (GP 33 [E]), as the consultation was viewed as something where the focus was on the patient and their concerns. In this regard, payment matters might perceivably cloud and affect the patient focus, at least in the mind of the GP: 'You don't want to give them [the patient] I suppose the impression that you would withhold treatment from them because they didn't pay or that you would temper future consultations' (GP 32 [E]).

GP 28 identified that their attitude was in contrast to their ownership aspirations. They appeared to struggle with personally reconciling this:

> I suppose it's nearly a contradiction in my own head that I feel I want to become a partner and I find it hard to ask people for money. If you're going to be a partner, you're going to have to be actively involved in finances as well and making sure that people are being charged for relevant services so that the practice can actually function. (GP 28 [E])

This seemed to be less of an issue for owners, who tended to adopt a more pragmatic attitude. Owners speaking about the issue did not generally make reference to discomfort; however, neither did they view matters coldly:

> (W)e do expect people to pay, but when people are unable to pay, even the secretary would be told if she gets any sense that someone is in financial difficulties, that they would just give us ... nod us a wink so that we won't be embarrassing people. (GP 9 [O])

A solution can be to pass on the responsibility to the administrative side of the practice. While internally efficient, this also helps the GP to avoid discussing money in the consultation. Therefore, they can distance themselves from this part of the transaction, putting the responsibility on 'management'. This separation is particularly interesting in the context of GP 1, who is already part of 'management' as the sole owner.

> As a clinician, as you know, we would listen to people talking about their difficult financial problems and whatever and sometimes, very often and certainly in years gone past, we would have said 'Look, don't worry about the fee' and whatever. The management now tend to be more aggressive about sending out bills. They have to strike a balance somewhere, you know. (GP 1 [O])

DISCUSSION

Interviewees acknowledge that, although caring clinicians and professionals are strongly oriented towards serving the needs of others at their core (Cogan, 1953; Freidson, 2001; Green, 2014; Vera and Hucke, 2009), they also operate commercially (Descombes, 2002; Fisher and Best, 1995; Spence and Carter, 2014) within micro/small

businesses and seek profits. As GPs, they incorporate two potentially opposing ideologies (Jain and Cassel, 2010). These represent different underlying values and, in this sense, may be incompatible (Gillies et al., 2009; IMO, 2012). Consequently, the 'business of caring' can be a challenge for the GP, as they fill a commercial role in addition to their professional role (Heller, 2012).

GPs seem compelled to address the dual goals of patient care and profit generation. Priorities are mixed; serving patient interests is critical, but so is business growth and sustainability as other interests (including their own) are also relevant. This creates a possible dilemma, as too much emphasis on one to the exclusion of the other may have adverse effects. Patients' needs may come first, reflecting a traditional professional ethos that is perhaps stronger in medicine (e.g. Vera and Hucke, 2009) than in other more 'commercially' oriented professions (e.g. Spence and Carter, 2014). However, service decisions reflect the realities of what the business can sustain, and GPs take steps to address payment in a manner that comfortably balances different needs. Thus, both patient and commercial perspectives are acknowledged with some mutuality, because there are no profits without patients, but equally, with no prospect of financial returns, the scope to deliver enhanced services is limited.

According to Piliavin and Charng (1990) and Wakefield (1993), altruism exists when the actor's behaviour entails some form of personal act for another's benefit. Research provides some support for the existence of altruistic tendencies among doctors in seeking to meet the care needs of patients (e.g. O'Donnell et al., 2011; Spoor and Munro, 2003). However, there is also evidence of possible self-interest (Jones and Green, 2006) and the influence of financial incentives (e.g. Croxson et al., 2001; McDonald et al., 2010). In this respect, the literature appears somewhat inconclusive as to which perspective, if any, dominates.

The research findings suggest that GPs are neither wholly altruistic nor wholly self-interested in simultaneously filling a professional and a commercial role, as they are motivated both intrinsically and extrinsically (Bénabou and Tirole, 2003; Ryan and Deci, 2000). This study supports a more nuanced middle-ground orientation (Batson and Powell, 2003; Maitland, 2002; Wicks, 1995), with elements of altruism and self-interest blending and co-existing (Bishop and Rees, 2007; Freidson, 1988; Jensen, 1994; Maier and Shibles, 2011). According to Downie (1986a), it is reasonable that the clinician pursues profits, without being unduly self-interested or greedy. Gillon (1986a) extends this by asserting that their treatment of patients, as a moral professional duty, is at least part altruistic and then only part self-interested. In this case, Gillon (1986b: 172) defines altruism as 'for the benefit of others', consistent with a middle-ground perspective. This recognises that the notion of 'pure' altruism – where the patient's needs are the sole motive and the anticipation of money does not come into the reckoning – is difficult to sustain in a caring profession that is also a business (Godager and Wiesen, 2011; Wicks, 1995) upon which the professional is directly dependent for his or her livelihood. While contingent financial rewards are earned, these do not appear to 'crowd out' (Frey and Jegen, 2001) intrinsic motivations. Instead, they satisfy the lower-order basic needs (Maslow, 1954) of any owner or employee, while also allowing the GP to resource and pursue higher-order needs through improving themselves, their practices and, ultimately, their offerings to patients.

The current study contends that this presents a more realistic picture of the GP as a professional, which does not eliminate the possibility that the individual can exceed their obligations, but simply that this is not the expectation. Instead, the GP should seek to satisfy the patient's interests because this is linked to their own interests (Maitland, 2002; Rubin, 2009; Wicks, 1995), and thus they should continue to seek further ways in which to profitably serve. This represents a virtuous cycle. Attaining profits and collecting cash ultimately benefits patients' long-term interests through the GPs' continued existence and availability, as well as their capacity and motivation for service enhancement and growth (Hausman and Le Grand, 1999; Mechanic, 1975). However, profitability is also contingent on suitably serving the patients and their continued presence as patients of the practice, controlling the levels of self-interest. Excessive commercialism evidently does not fit well with doctors (Vera and Hucke, 2009) and can be met with some criticism among GPs themselves; where it exists, such an approach may adversely influence patient retention (Hausman and Le Grand, 1999). Consequently, the absence of some degree of reasonable self-interest may be indirectly harmful to the needs of patients and, therefore, not ultimately 'altruistic' because the poor performance or failure of the practice is not to the 'benefit' of patients.

LIMITATIONS AND IMPLICATIONS

This paper is based on a purposively selected sample of 35 GPs and, thus, it may not be possible to generalise extensively. However, the interviewees are representative of the types of GPs working in practices and provide

valuable insights into, and examples of, the typical challenges encountered in such businesses. In spite of this limitation, the paper draws attention to an area of important debate within the literature and provides suggestions as to how this may be reconciled.

Although altruism may traditionally underpin the behaviour of clinical professionals (Pellegrino, 1987; RCP, 2005), this study contends that viewing them as altruistic in isolation of business needs is unrealistic and unsustainable. Given that the time period during which the primary data collection occurred coincided with a global financial crisis, it is understandable that participants were acutely concerned about survival and the future for their practices, in addition to delivering quality service to their patients. This reflects a modern and enduring reality for all businesses, beyond the crisis period, and means that even those in the front-line caring professions need to take a pragmatic view of what is and is not achievable with the restricted resources available (e.g. GPs 1 and 22). However, the notion that an emphasis on commercialism and profit in healthcare might be taking over (Mechanic, 1996; Relman, 2007) appears excessive. Instead, a blending of interests is possible (Gillon, 1986a, 1986b; Maier and Shibles, 2011), with positives for both patient and practitioner; by pursuing reasonable self-interest (Maitland, 2002), the best interests of the patient are ultimately met (Rubin, 2009) as one complements the other. Thus, GPs should not be concerned about also being viewed as 'businesspeople' and seeking to hide their duality (Descombes, 2002), but, rather, they need to demonstrate how a successful practice ultimately benefits patients. Retaining distance between service provision and the act of payment helps to avoid a certain discomfort, though this may become less of an issue in the future (see below). However, in order to remain patient-focussed GPs, the latter must retain essential services and suitably enhance their offering; this requires cash (from making profits) for continuity and reinvestment in new offerings, facilities and technologies. Therefore, positively balancing both the motivations (intrinsic and extrinsic) is a viable, sustainable and mutually favourable approach to adopt for the professional.

This paper does not go as far as Heller (2012) to suggest that the financial rewards earned by GPs are 'by-products' of what they are expected to do as professionals, as this may give the impression that such rewards were not thought about in undertaking the professional activity. Instead, it is contended that the needs of the patient and the practice are both important and considered to some degree in making decisions, and they are strongly linked to each other. Following from this, one could argue that the rewards received are more in the line of a 'co-product' of service delivery and a critical prerequisite of practice continuity and quality. Thus, the traditional professional value of community interest and the needs of others (Cogan, 1953; Freidson, 2001) remains present in general practice, but this is balanced by commercial realities and self-needs (Freidson, 1988; Jones and Green, 2006). Neither entirely dominates, suggesting that our understanding of the nature of professionals and what 'vocation' means requires careful reconsideration through a modern lens. If all needs are not sensibly considered, even by the less ostensibly 'commercial' professional, then none will ultimately be met. This is a contemporary dilemma for the professional generally – and the GP specifically – that appears to be best resolved through the adoption of a more balanced orientation between professional and commercial demands, to the overall benefit of patient and practice. Future research could seek to understand, in even greater depth, how current GPs themselves actually conceptualise the nature of being a professional in the face of growing challenges to the more traditional elements and how this affects their typical work behaviours.

With free GP care for all in Ireland planned on a phased basis, it is important that state bodies recognise how GPs reflect on both motives and orientations in their decision-making process (Batson and Powell, 2003). This has already been demonstrated in the reservations raised by GPs over the contract for children <6 years of age (Medical Independent, 2015), introduced in 2015, and their reactions to the scheme, whereby services are provided by the GP at no cost to the patient at the point of access. The calls for resources, the expressed implications for service delivery and the seeming inequity towards certain patient categories (Behan et al., 2014; Irish College of General Practitioners (ICGP), 2014a, 2014b; LHM Casey McGrath, 2015) indicate that GPs are concerned about the effect of contractual changes on their businesses and on their patients. Notably, the agreement reached (and ultimately signed up to by a considerable majority) entailed an increase in payment levels as well as improved care for some chronic illnesses, potentially benefitting both GPs and patients.

Thus, this study contends that remuneration structures in future contracts need to recognise how GPs can react to financial incentives rationally in a self-interested manner, as noted by Croxson et al. (2001), Pockney et al. (2004), Walley et al. (2000) and Whynes et al. (1999). However, these structures must also ensure that their underlying altruistic professional values and demonstrable behaviours are appropriately reflected (Hausman and Le Grand, 1999; Spoor and Munro, 2003; Young et al., 2012) and not adversely interfered with. Consistent with GP reactions to the 'Under 6' contract, the findings show how money matters do come into decisions that GPs make

(articulated clearly by GPs 10 and 35), but this is very much guided by the vital needs of patients (e.g. GPs 9 and 22). Both moral and financial motivations exist, and incentives and professional values should ideally be aligned (Campbell et al., 2007; McDonald and Roland, 2009). Thus, blunt instruments that seek to manipulate GPs in a particular direction may not be effective because although they are in business, they are more than a micro/small business owner or member.

The current governmental approach comprising payments of a predominantly capitation nature needs to be carefully considered, as this may not adequately motivate GPs to enhance service availability (Mechanic, 1975). Conversely, a system of incentives, based on achieving targeted outcomes, might not be patient centric (McDonald et al., 2008, 2010). It is beyond the scope of this paper to recommend one or the other; rather, this paper aims to highlight this issue and to warn that careful consideration of all approaches is essential at a policy level. This observation is also valid in an international context, where the debate around how best to incentivise doctors is unresolved (Green, 2014; Heller, 2012; Jain and Cassel, 2010; Kontopantelis et al., 2014) across all levels of healthcare. The current study recommends that policy-makers reflect and recognise the potentially conflicting intrinsic and extrinsic motivations of GPs. Simplistic assumptions that doctors are merely caring altruists or self-interested rationalists should be avoided; they are considerably more complex and function within a challenging, resource-restricted context wherein quality and efficiency both matter. In this respect, subtlety, flexibility and balance in policy settings can be rewarding, as aligning reasonable and realistic levels of altruism and self-interest within incentive mechanisms may help to deliver the promise of improved quality and lower cost, without the threat to professionalism feared by some.

CONCLUSION

The current study has sought to increase the understanding regarding how GPs – as professionals – address the apparently opposing motivations stemming from being altruistic and self-interested, as well as the implications stemming from this duality. This paper recognises the need for research, in an Irish healthcare context, which addresses the issue of financial incentives (Brick et al., 2012), and in a wider international context, as to how healthcare professionals interpret the meaning of such incentives (Young et al., 2012). Overall, the research indicates that GPs can be viewed as 'part altruistic, part self-interested', acknowledging that they are both patient- and profit-focussed professionals. While they may veer in the direction of patients' interests, reflecting their strong professional anchor, GPs also recognise the need for reasonable balance to maintain themselves commercially. This should be encouraged and viewed positively, being ultimately of benefit to both patients and doctors in resource-restricted times. A successful practice is a sustainable practice, with an appetite for improvement, while meeting the interests and needs of their patients. However, that success is contingent upon maintaining a broadly patient-centred focus. It is important that this thinking is instilled in the development of new GPs and doctors; future studies could consider how such training might be structured/delivered, given the traditional emphasis on clinical learning. Furthermore, there is a need for additional research to assess how best to remunerate GPs if patient care is to be free at the point of delivery under an effective system. Recognising the complex and inter-related motivations of GPs and doctors, as highlighted in this study, is an essential early step in any system design.

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ENDNOTES

1 Fundholding is a system whereby particular UK GPs were allocated a fixed budget, from which they would pay certain patient-related costs, being allowed to retain the savings for investment in capital assets, staff and services.
2 The framework is a performance management system in the UK, forming the basis for certain payments to GPs.
3 Small business is defined as an independent enterprise with between 10 and 49 employees, while micro-firms have up to nine employees (Wymenga et al., 2011).

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