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Developing a better targeted virtue ethics approach to medical regulation

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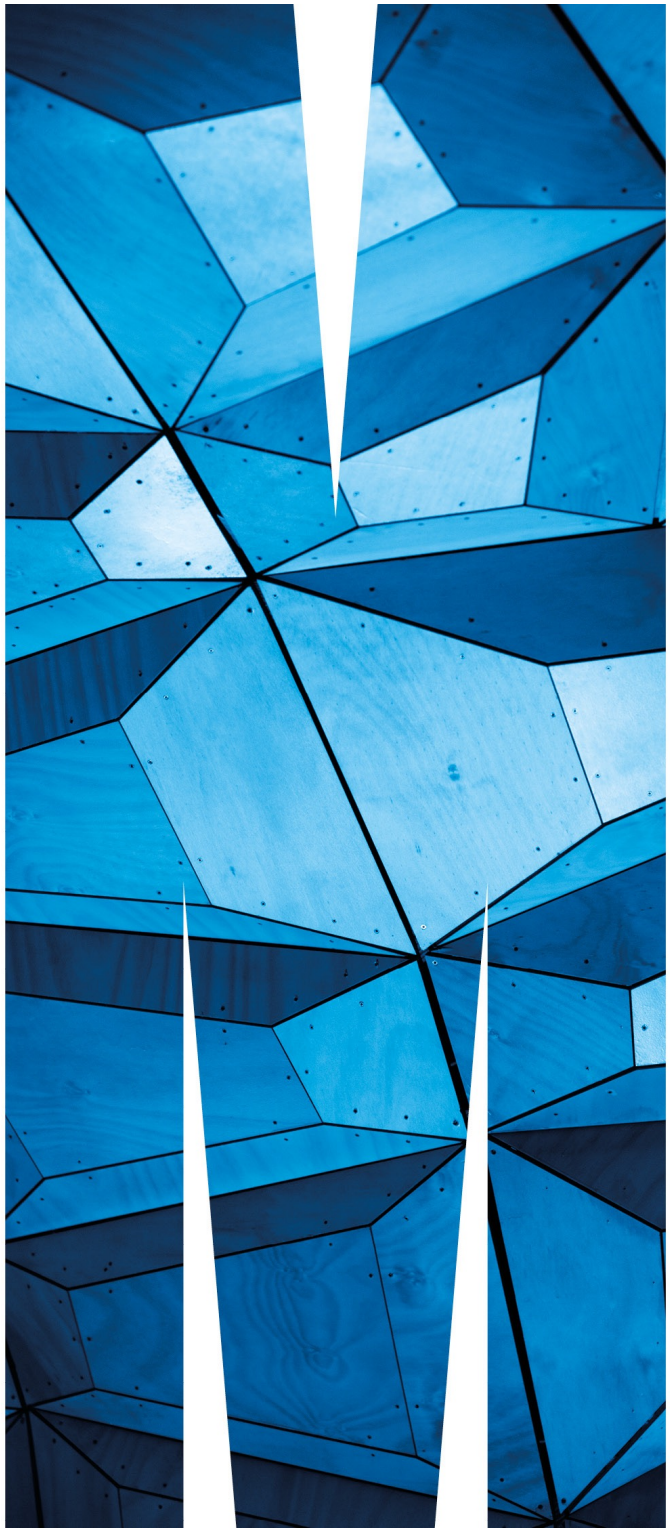

Outline

- Virtue ethics can plausibly evaluate medical policy directly by focusing on the *priorities* which are centrally involved in each medical virtue, and examining evidence of the impact of a given policy or regulatory change on medically virtuous behaviour – where such behaviour is understood as involving doctors *prioritising* the relevant considerations in their clinical practice.

- On this approach, for example, a policy intervention into doctors' pharmaceutical prescribing behaviour can be evaluated by considering the likely impact of the policy intervention on the disposition to medical beneficence exhibited by doctors – understood as including a core disposition to prioritise their patients' best interests in the doctor's prescribing decisions.

- Also, I distil some generalisable lessons which this policy approach can provide about conceptual links between the priorities of agents and:

  (i) the nature of medical virtue, and virtue more generally;

  (ii) the meaning of *therapeutic relationships* between doctors and patients.

Towards a better-targeted virtue ethics approach to regulating medical practice

- Recent applications of virtue ethics to policies governing professional practice have suggested that organisations should create virtue-conducive workplace environments (see eg. Conroy 2010; Whetstone 2017). That is, policymakers can investigate whether the institutional environments that various practitioners operate within are conducive to practitioners developing and exercising the relevant professional role virtues.
  - For example, given that role virtues (like all virtues) include an awareness of situational and environmental factors conducive to or undermining of virtuous behavior, policymakers could design institutional environments which help to raise practitioners' awareness of when various well-known biases and cognitive errors are likely to divert role virtues from hitting their targets.
- In designing policies that help practitioners to identify and contend with various pro-virtue and contra-virtue environments, policymakers can be plausibly interpreted as assisting practitioners to develop and maintain role-appropriate character traits.

- Virtue ethics can more directly evaluate policies regulating professional practice, by focusing on the *priorities* which are centrally involved in the key role virtues for the profession in question, and examining evidence of the impact of a given policy or regulatory change on professionally virtuous behaviour – where such behaviour is understood as involving practitioners *prioritising* the relevant considerations in their professional practice.

Role virtues and properly-oriented doctor-patient relationships

Policymakers could facilitate and help develop practitioners' professional role virtues through reflecting on the connections between such role virtues and good doctor-patient relationships. For in reflecting on these connections, policymakers could consider how supporting the proper orientations of those relationships can at the same time support practitioners having and acting on the relevant role virtues.

For example, policies which support doctors maintaining therapeutic relationships with patients also thereby support doctors acting on the virtue of medical beneficence. The professional medical associations of many countries already urge doctors in those jurisdictions to maintain therapeutic relationships with patients.

> For instance, in its Position Statements and Guidelines, the Australian Medical Association (AMA) often makes reference to the importance of doctors protecting therapeutic relationships with patients from various commercial and other external influences.

What seems central to the characterisation of a doctor-patient relationship as a therapeutic relationship is whether the doctor's clinical decisions about each patient (such as the doctor's medication prescribing decisions) are governed by a genuine commitment to serve that patient's best interests (even if the medications prescribed by the doctor sometimes unforeseeably fail to do so).

Therefore, in being expected to maintain a therapeutic orientation in their clinical decisions and in their professional relationships with patients, doctors thereby seem expected to (inter alia) apply certain sorts of governing conditions to guide those decisions and relationships (whatever the personal character of an individual doctor might be).

Applying this virtue ethics approach to policy regulating *medical* practice

Two examples:

(1) The impact on the virtue of medical beneficence and therapeutic doctor-patient relationships of policies creating certain institutional incentives – such as *Fee-for-service* payments – which evidently have the unintended consequence in end-of-life care of encouraging hospitals and doctors to acquiesce to requests from patients' families to provide life-prolonging procedures to dying relatives, even when those procedures are contrary to patients' best interests.

(2) A policy intervention into doctors' pharmaceutical prescribing behaviour can also be evaluated by considering the likely impact that this intervention may evidently have on doctors acting on the virtue of medical beneficence – where this is understood as including a core disposition to prioritise their patients' best interests in their prescribing decisions.

→ For instance, consider the legalisation of *Direct-to-consumer advertising (DTCA) of prescription pharmaceuticals*. On the virtue ethics policy approach I am proposing, policymakers could evaluate whether DTCA of prescription pharmaceuticals should be (or remain) legally permitted by examining empirical studies of the impact that laws allowing this practice evidently have on therapeutic relationships between doctors and patients, and thus on doctors' role virtue of medical beneficence.

(1) Fee-for-service payments in end-of-life care

Medical over-servicing is a significant problem worldwide, and regulatory environments are recognised as key contributors to this problem.

For example, fee-for-service arrangements in medical practice are known to result in significant levels of over-servicing in end-of-life care:

> "Generous fee-for-service payments give physicians incentives to – even in the final weeks of life – provide high-intensity, high-cost services, consult multiple subspecialties, order tests and procedures, and hospitalize patients. And because referring patients to hospice reduces the income of some other providers, the fee-for-service system discourages timely referrals to hospice" (IOM Report 2015, p. 276).

These patterns of practice often result in serious harms to patients, impose significant additional costs onto the community, and are contrary to the social remit given to doctors.

(2) DTCA and doctors' priorities

What does evidence tell us about the governing conditions of doctors' prescribing decisions in jurisdictions – such as the US – where pharmaceutical DTCA has been legalised?

Much evidence suggests that legalised pharmaceutical DTCA increases clinically inappropriate prescribing, by increasing patient requests for specific drugs seen advertised, and by raising the levels of physicians' acquiescence to such requests (see eg. Murray 2003, 2004; Mintzes 2002, 2003). Mintzes et al (2003, p. 412) concluded that:

> "If DTCA opens a conversation between patients and physicians, that conversation is likely to end with a prescription, despite frequent physician ambivalence about treatment choice. And the greater the patient's exposure to advertising, the more likely such a conversation will occur".

Also, the first systematic review of the benefits and harms of DTCA found that:

> "Direct to consumer advertising is associated with increased prescription of advertised products, and there is substantial impact on patients' requests for specific drugs and physicians' confidence in prescribing', and corroborated the view that physicians often accede to patient demands for the advertised drug, despite physicians' misgivings about the drug in question" (Gilbody, Wilson, and Watt 2005, p. 246).

A subsequent systematic review examined studies of pharmaceutical DTCA effects since 2005 and reached similar overall conclusions, and reinforced concerns about the impact of pharmaceutical DTCA on doctors' prescribing behaviour:

> "RCT and observational study evidence indicates that DTCA leads to less appropriate prescribing, in which physicians have less confidence" (Mintzes 2012, p. 271).

So, there seems to be strong evidence that direct-to consumer advertising of prescription pharmaceuticals significantly increases clinically inappropriate prescribing.

DTCA and doctors' priorities

The evidence indicates that the increase in clinically inappropriate drug prescribing in DTCA environments is largely due to two key factors:

(1) Doctors working in DTCA environments face greater demands from patients for clinically inappropriate medication; and

(2) Doctors often find it difficult to resist such brand-specific demands from patients.

Further, while many doctors working in DTCA jurisdictions appreciate that acquiescing to patients' brand-specific requests may lead to patients receiving clinically inappropriate medications, there is evidence that some doctors nevertheless go ahead with prescribing clinically inappropriate medications (see also Weissman 2004).

Indeed, a doctor may be very aware of their own biases and might develop various metacognitive strategies to mitigate them, but where even a situationally-aware doctor (for one reason or another) wrongly *prioritises* certain values in the choices they make in their professional role, they are failing to uphold the relevant regulative ideal (hit the target) of the relevant virtue here.

And, regularly engaging in clinically inappropriate prescribing behaviour arguably redefines the doctor-patient relationship as something other than a therapeutic relationship, whereby doctors fail to exhibit the virtue of medical beneficence. Insofar as this is so, there seems good evidence for supposing that legalised pharmaceutical DTCA undermines a central medical virtue.

Fee-for-service payments in (eg.) end-of-life care |→	Significant levels of over-servicing in end-of-life care |→	Redefining therapeutic doctor-patient relationships|→	Undermining medically virtuous behaviour ||→	Undermining medical virtue

Legalisation of pharmaceutical DTCA (USA 1997) |→	Significant increase in clinically inappropriate prescribing |→	Redefining therapeutic doctor-patient relationships|→	Undermining medically virtuous behaviour ||→	Undermining medical virtue

A matrix of possible regulatory responses: eg. DTCA

***High* levels of clinically inappropriate physician acquiescence**	Prohibit DTCA	Prohibit DTCA	??
***Moderate* levels of clinically inappropriate physician acquiescence**	Prohibit DTCA	Prohibit DTCA?	Strengthen relevant medical virtues in physicians
***Minimal* clinically inappropriate physician acquiescence**	??	Strengthen relevant medical virtues in physicians	Strengthen relevant medical virtues in physicians
	***Little* prospect of improvement via other regulatory interventions (other than banning DTCA)**	***Considerable* prospect of improvement via other regulatory interventions (other than banning DTCA)**	***Much* prospect of improvement via other regulatory interventions (other than banning DTCA)**

Considering priorities in virtues generally

The focus in this policy approach on a practitioner's *priorities* can also provide insights into the structure of virtues more generally (outside professional practice), as many Aristotelian virtues significantly involve (among other things) agents prioritising certain considerations over others, and developing those virtues includes (among other things) learning which considerations to prioritise in what circumstances.

Agents' priorities in Aristotelian virtues

In his accounts of virtues in the *Nicomachean Ethics*, Aristotle emphasises how virtues include (among other things) awareness of the considerations and values at stake in a situation, understanding which considerations to prioritise in that situation, and *prioritising* those considerations in one's response to that situation.

In discussing the nature of virtue (in NE II, 5), Aristotle highlights how "the virtues are modes of choice or involve choice" (NE 1106a3, trans. Ross), and his initial statement about the virtues of temperance and courage illustrates how he takes those virtues to involve making certain choices (and avoiding other choices):

> "both excessive and defective exercise destroys the strength, and similarly drink or food which is above or below a certain amount destroys the health, while that which is proportionate both produces and increases and preserves it. So too is it, then, in the case of temperance and courage and the other virtues. For the man who flies from and fears everything and does not stand his ground against anything becomes a coward, and the man who fears nothing at all but goes to meet every danger becomes rash; and similarly the man who indulges in every pleasure and abstains from none becomes self-indulgent, while the man who shuns every pleasure, as boors do, becomes in a way insensible; temperance and courage, then, are destroyed by excess and defect, and preserved by the mean" [NE 1104a15-25, trans. Ross]

Agents' priorities in the virtue of courage

In his subsequent more detailed discussion of the virtue of courage, Aristotle argues that courage includes an understanding of what sorts of purposes it is worth enduring what risks of danger for, and prioritising the pursuit of those purposes over the risks involved in pursuing them:

> "the case of courage is similar, death and wounds will be painful to the brave man and against his will, but he will face them because it is noble to do so or because it is base not to do so. And the more he is possessed of virtue in its entirety and the happier he is, the more he will be pained at the thought of death; for life is best worth living for such a man, and he is knowingly losing the greatest goods, and this is painful. But he is none the less brave, and perhaps all the more so, *because he chooses noble deeds of war at that cost*" [NE 1117b7-15, my emphasis].

Failures of courage as involving the wrong priorities

Indeed, many of the various ways Aristotle discusses (in *Nicomachean Ethics* 1115b25ff) in which an agent can *fail* to be courageous can also be instructively understood as ways in which the agent prioritises the considerations involved inappropriately:

> "The coward, the rash man, and the brave man, then, are concerned with the same objects but are differently disposed towards them; for the first two exceed and fall short, while the third holds the middle, which is the right, position; and rash men are precipitate, and wish for dangers beforehand but draw back when they are in them, while brave men are keen in the moment of action, but quiet beforehand" [NE 1116a5-10].

Agents' priorities in the virtue of temperance

Similarly, in his discussion of the virtue of temperance, Aristotle argues that the 'self-indulgent' person who lacks this virtue prioritises inappropriately in the choices that they make:

> "The self-indulgent man, then, craves for all pleasant things or those that are most pleasant, and is led by his appetite *to choose these at the cost of everything else*" [NE 1119a1-3, my emphasis].

Also, the self-indulgent person has the wrong priorities in what they especially delight in, as Aristotle says, regarding the pleasures of taste:

> "To delight in such things, then, *and to love them above all others*, is brutish" [NE 1118b4-5, my emphasis].

By contrast, "the temperate man craves for the things he ought, as he ought, and when he ought." [NE 1119b17-18]

Thus, Aristotelian temperance can be helpfully understood as centrally involving 'rightly-ordered appetites' (see Trianosky 1988).

Concluding comment

I am not arguing that the manifest importance of a practitioner's priorities in medical practice (and in other professions) *reveals* that priorities are also key aspects of virtues generally (ie. outside professional contexts).

After all, I have set up the overall argument in this presentation by highlighting the links between priorities and virtues.

Rather, my point in the last section of the presentation is that, in reminding us of and highlighting the centrality of priorities in various key Aristotelian *general* virtues, this can in turn provide some vindication of the prominence that I have given to agents' priorities and prioritising in *professional role* virtues (such as role virtues in medical practice).

References

Aristotle, *The Nicomachean Ethics* (trans. W.D. Ross), Oxford, Oxford University Press, 1980.

Mervyn Conroy, *An Ethical Approach to Leading Change*, Basingstoke, Palgrave Macmillan, 2010.

S Gilbody, P Wilson, and I Watt. 'Benefits and Harms of Direct-to-Consumer Advertising: A Systematic Review', *Qual Saf Health Care* 14, 2005, pp. 246-250.

Institute of Medicine, Dying in America: Improving quality and honoring individual preferences near the end of life, National Academies, 2015. https://www.nationalacademies.org/read/18748

Bernard Lo and Marilyn J. Field (eds.), *Conflicts of Interest in Medical Research Education, and Practice*, Institute of Medicine, Washington, National Academies Press, 2009.

Barbara Mintzes et. al.. 'Influence of Direct to Consumer Pharmaceutical Advertising and Patients' Requests on Prescribing Decisions: Two Site Cross Sectional Survey', *BMJ* 324, 2002, pp. 278-279.

Barbara Mintzes et. al., 'How does Direct-to-Consumer Advertising (DTCA) Affect Prescribing? A Survey in Primary Care Environments with and without Legal DTCA', *CMAJ* 169, 2003, pp. 405-412.

Barbara Mintzes, 'Advertising of Prescription-Only Medicines to the Public: Does Evidence of Benefit Counterbalance Harm?' *Annual Review of Public Health* 33, 2012, pp. 259-277.

E. Murray et. al., 'Direct-to Consumer Advertising: Physicians' Views of its Effects on Quality of Care and the Doctor-Patient Relationship', *J Am Board Fam Med* 16, 2003, pp. 513-524.

E. Murray et. al., 'Direct-to Consumer Advertising: Public Perceptions of its Effects on Health Behaviors, Health Care, and the Doctor-Patient Relationship', *J Am Board Fam Med* 17, 2004, pp. 6-18.

Justin Oakley, 'Creating regulatory environments for practical wisdom and role virtues in medical practice' in David Carr (ed.), *Cultivating Moral Character and Virtue in Professional Practice*, London, Routledge, 2018, pp. 83-95.

Justin Oakley, 'Role virtues, doctor-patient relationships, and virtuous policy', in Tim Dare and Christine Swanton (eds.), *Perspectives in Role Ethics: Virtues, Reasons, and Obligation*, Abingdon, Routledge, 2020, pp. 160-170.

Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, Cambridge, Cambridge University Press, 2001.

A. Tentler, A. et al., 'Factors affecting physicians' responses to patients' requests for antidepressants: Focus group study', *Journal of General and Internal Medicine*, 23, no. 1, 2008, pp. 51-57.

Gregory W. Trianosky, 'Rightly-ordered appetites: How to live morally and live well', *American Philosophical Quarterly* 25, no. 1, January 1988, pp. 1-12.

J.S. Weissman et al., 'Physicians report on patient encounters involving direct-to-consumer advertising', *Health Affairs (Millwood)* (suppl web exclusives), 2004, pp. W4.219–W4.233.

J. Thomas Whetstone, 'Developing a Virtuous Organizational Culture', in A. Sison, G. Beabout, and I. Ferrero (eds) *Handbook of Virtue Ethics in Business and Management*, Dordrecht, Springer, 2017.