Maintaining primary professional virtues by protecting properly-oriented relationships: Medical practice as a case study

Justin Oakley

This is an unpublished conference paper for the 3rd Annual Jubilee Centre for Character and Virtues conference at Oriel College, Oxford University, Thursday 8th – Saturday 10th January 2015.
These papers are works in progress and should not be cited without author's prior permission.

Jubilee Centre for Character and Virtues
University of Birmingham, Edgbaston, Birmingham, B15 2TT United Kingdom
T: +44 (0) 121 414 3602 F: +44 (0) 121 414 4865
E: jubileecentre@contacts.bham.ac.uk W: www.jubileecentre.ac.uk

Maintaining primary professional virtues by protecting properly-oriented relationships: Medical practice as a case study

Justin Oakley, Centre for Human Bioethics, Monash University

In being entrusted with serving certain socially-valued goals, professionals are expected to be guided by specific normative dispositions. These dispositions help to define and distinguish between various kinds of good professional-client/patient relationships. For example, to qualify as a therapeutic relationship a doctor-patient relationship must not only promote the patient's health, but must arguably also involve the doctor being governed in their clinical decision-making by a commitment to serving their patient's best health interests. In this paper I argue that protecting the proper orientation of professional-client/patient relationships is a crucial way of maintaining the respective primary virtues among practitioners in each profession. For example, taking medicine as a case study, I argue that the primary medical virtue of medical beneficence is (and should be) supported by protecting the therapeutic orientation of doctor-patient relationships against potentially undermining influences. I focus here on the impact on doctors' prescribing behaviour of various commercial influences – via patients, and directly upon doctors – as case studies to illustrate this proposal. More specifically, I consider direct-to-consumer-advertising of prescription pharmaceuticals, and on pharmaceutical marketing activities aimed directly at doctors, as case studies to illustrate this proposal. In doing so, I also hope to show how extending professional role applications of virtue ethics can provide an instructive way of developing policy applications of virtue ethics, and that virtue ethics can thereby help in achieving certain sorts of important policy goals.

Promoting professional virtue through the governing conditions of professional relationships

In recent years there have been striking advances in applications of virtue ethics to right action in the context of various roles, such as medical practice, parenting, and personal relationships. This is especially true of Aristotelian forms of virtue ethics, where accounts have been developed of role-differentiated virtues that demonstrably serve the proper goals of the profession or practice in question, thus mirroring Aristotle's teleological account of how broad-based virtues enable us to live humanly flourishing lives. So, a key feature of contemporary Aristotelian virtue ethics evaluations of actions within roles is the central place given to the proper goals of the profession or practice in question, and to showing how a commitment to these goals should regulate or govern a practitioner's conduct in the context of that role. For example, medical end-of-life decisions can be evaluated according to whether they demonstrate relevant virtues – such as medical beneficence, a character trait enabling a doctor to

act in the best interests of the patient in question so as to help make the patient 'whole' (which is arguably the essence of *healing*).[1] In certain circumstances this virtue might involve helping the patient to achieve a fitting completion of their life in accordance with their own values, and so not prolonging the patient's life against their wishes. In such ways a virtuous doctor's conduct in clinical practice is governed by a *regulative ideal* of serving the health of their patients, an ideal which a virtuous doctor has internalized as a normative disposition guiding and justifying their clinical decisions and actions, without necessarily being consciously invoked in their every decision. Acting on the relevant medical virtues in such contexts also requires a doctor to act out of certain *motives* towards their patients, such as care and compassion, in the case of medical beneficence. The motives a doctor acts from can be distinguished conceptually from the *governing conditions* which guide their behaviour. For example, it seems possible that a doctor whose prescribing decisions are governed primarily by their goal of retaining the wealthiest patients in the area could still act from motives of empathy in their medication prescribing decisions towards at least some of those patients. And, considering governing conditions operating at a higher level, a doctor who practices in remote areas only on the condition that s/he is paid a significant financial incentive to do so might nevertheless act from motives of care and compassion rather than personal profit in treating individual patients in such areas. As such examples illustrate, it can be difficult to detect what motives a doctor is genuinely acting from in any given case. However, doctors' governing conditions are, arguably, somewhat more amenable to empirical study than their motives are commonly thought to be, as I indicate shortly. And, as I argue below, an evidence-based virtue ethics approach to public policy can legitimately focus on the – likely or actual – impact of a proposed policy on the proper governing conditions of various professional-client relationships, and so need not rely on ascertaining how such a policy might affect the motives which practitioners act from in those relationships.

The governing conditions which two parties apply to their relationship can provide a crucial way of distinguishing between various kinds of relationships, such as friendships and good doctor-patient relationships. For example, a preparedness to terminate one's professional relationship with a patient once they are healed does not seem incompatible with this counting as a good doctor-patient relationship, whereas being disposed to terminate a personal relationship because one no longer needs assistance from the other party does seem inconsistent with that relationship being a genuine

[1] See Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, Cambridge, Cambridge University Press, 2001, chapter 3.

friendship.[2] Moreover, a practitioner's professional character and virtues (or otherwise) can often be revealed in the nature of the professional relationships that they develop and maintain with their patients and clients. Thus, consider, for example, the expectation upon doctors to maintain therapeutic relationships with their patients. The Australian Medical Association's (AMA) current Code of Ethics advises doctors to "Recognise that an established therapeutic relationship between doctor and patient must be respected" (1.1.14).[3] Indeed, it is well-known that developing and maintaining a therapeutic relationship with patients is particularly important in mental health care, where patients are often asked to disclose highly intimate details about themselves – and so the success of treatment often relies on patients trusting that their practitioner is guided in his/her clinical decision-making by the best interests of his/her patients. But what may well be overlooked is that what *makes* a particular relationship count as a therapeutic relationship seems not only to be that the outcomes of the doctor's clinical decisions about that patient largely turn out to be in this patient's best interests. For example, it is doubtful that a psychiatrist whose medication prescribing decisions regarding a certain patient were governed primarily by the interests of a pharmaceutical company from whom they receive significant consulting money could plausibly be thought to have a therapeutic relationship with this patient, even if the medications thus prescribed largely end up being in the best interests of that patient. What seems more central to the characterization of a doctor-patient relationship as therapeutic is whether the doctor's medication prescribing decisions (and other clinical decisions about that patient) are governed by a genuine commitment to serve their patient's best interests (even if the medications thereby prescribed sometimes unforeseeably fail to do so). Thus, in being expected to maintain a therapeutic orientation in their clinical decisions and their professional relationships with patients, doctors thereby seem expected (among other things) to apply certain sorts of governing conditions to guide those decisions and relationships.

But why should we think that the nature of the professional relationship a doctor has with a particular patient can reveal the presence (or absence) of certain medical virtues in the doctor? Here is my argument for this suggestion. If one accepts the above claim that the nature of a doctor-patient relationship (eg. as therapeutic or otherwise) is importantly determined by the sorts of governing conditions which the doctor applies to their clinical decision-making about the patient (and not simply by what the outcomes of those decisions turn out to be), then the nature of that relationship can reveal the presence (or absence) of certain medical virtues because having those virtues itself importantly involves (among other things) applying certain governing conditions to one's clinical decisions and

[2] See Oakley and Cocking, op. cit.; and Dean Cocking and Justin Oakley, 'Indirect Consequentialism, Friendship, and the Problem of Alienation', *Ethics* 106, no. 1, October 1995.
[3] See: *https://ama.com.au/codeofethics*

professional relationships with patients. If, for example, a doctor's prescribing decisions towards a particular patient were governed primarily by the doctor's own (eg. financial) self-interest rather than by this patient's best health interests, then that would clearly count against any claim that the doctor has and acts on the virtue of medical beneficence – at least in the context of their medication prescribing decisions regarding this patient. This is not to suggest that *all* features of professional-patient/client relationships which help define them as being of one (morally significant) sort or another will be virtue-involving. For example, institutional constraints on Australian doctors' consultation times limiting standard appointments with public patients to a maximum of 20 minutes duration may at times result in such relationships being somewhat impersonal – and being influenced in one's clinical decision-making by such constraints would typically reveal little about a particular doctor's professional moral character. By contrast, the considerations a doctor is guided by in their medication prescribing decisions for their patients seem to be central and significant indicators of whether the doctor in question has the virtue of medical beneficence.

Doctors committed to have and act on medical virtues such as medical beneficence, and medical courage, when they joined the profession.[4] Where policymakers and regulators profess to share the AMA's commitment to protecting the therapeutic orientation of doctor-patient relationships from distorting influences, it follows from the above argument that policymakers and regulators must consider what sorts of governing conditions doctors evidently apply in their clinical decision-making about patients. This is a question which is amenable to empirical study in particular contexts, such as doctors' medication prescribing decisions, as I will explain below. Therefore, when policymakers support (or for that matter, fail to support) doctors developing and maintaining therapeutic relationships with patients, policymakers are thereby supporting (or failing to support) doctors developing and acting on certain critical medical virtues, such as medical beneficence. This is a key example of how states and regulators (and indeed, professional associations and educators) can quite legitimately – and indeed, must – consider the impact of current and proposed policies on the professional virtues of the sorts of practitioners in question.

Promoting medical virtue by addressing nontherapeutic influences on doctors' prescribing

I will now consider two case studies from medical practice, to illustrate how the suggestions outlined above can provide an attractive approach for applying virtue ethics to public policy, and to professional

[4] I do not mean to imply here that this commitment is necessarily made explicitly by all doctors; rather, this commitment is sometimes an implicit one.

education and training. Both of the examples I discuss below concern risks of various commercial influences undermining therapeutic prescribing, either indirectly through patients, or by such influences acting directly upon doctors. In the first case – the regulation of pharmaceutical direct-to-consumer advertising (DTCA) – the focus is on current policy, whereas in the second case – the regulation of pharmaceutical marketing aimed at doctors – the focus will be on both current and possible future policies. In both cases, the proper goal of the profession in question – here, the medical profession – continues to play a key role in the analysis, when moving from evaluating the ethics of an individual medical decision, to evaluating the ethics of a policy on such decisions.

Pharmaceutical Direct-to-Consumer-Advertising

If the nature of a relationship is defined largely by its governing conditions, what does the evidence suggest *are* the governing conditions of doctors' clinical decisions – and their drug prescribing decisions, in particular – in an environment of legalized pharmaceutical DTCA? And, thus, how might legalized DTCA influence doctor-patient relationships? Addressing these questions will also help to illuminate whether or not legalizing pharmaceutical DTCA undermines doctors developing, maintaining, and acting on relevant medical virtues, such as medical beneficence. There is considerable evidence that legalized pharmaceutical DTCA increases clinically inappropriate prescribing[5] – largely by increasing both brand-specific requests from patients, and levels of physician acquiescence to such requests. Indeed, there is a growing body of evidence indicating that, while many doctors in environments of legalized pharmaceutical DTCA realize that acquiescing to a patient's brand-specific request will sometimes result in the patient receiving a clinically inappropriate medication, some of those doctors will nevertheless proceed with prescribing a clinically inappropriate drug for the patient, in any case. Given the argument I presented in the preceding section, a persistent pattern of such prescribing behavior would seem to redefine the doctor-patient relationship into something other than a therapeutic relationship, and the doctor would thereby relinquish the virtue of medical beneficence in that relationship. Thus, there are good grounds for thinking that legalized pharmaceutical DTCA evidently undermines medical virtue.

The available evidence indicates that increases in clinically inappropriate prescribing in legalized pharmaceutical DTCA environments are due to several related factors. Patients are often led by the advertising techniques used in DTCA to develop strong preferences for the advertised drug, and many such patients express those preferences in their medical consultations by requesting the advertised

[5] By 'clinically inappropriate prescribing' I am referring to prescribing a medication which there is good reason to believe is not in the best health interests of the patient, compared with other available medication(s).

drug.[6] Moreover, doctors will often respond by prescribing the requested drug, and the evidence suggests that some doctors will do so, even where they regard the drug they are prescribing as clinically inappropriate for the patient in the circumstances, and so as one that they would not otherwise have prescribed for the patient. Thus, a 2003 survey of a representative sample of US doctors found that 74% of the 535 respondents had seen patients who had discussed pharmaceutical DTCA information with them in the previous 12 months, and 48% of those patients discussed such advertising because they wanted a change in medication – which in almost half of those cases (ie. in 108 cases) the doctor regarded as clinically inappropriate. Nevertheless, in 75 of these 108 cases, the doctor did what the patient wanted (either partially or fully). The researchers concluded that "DTCA results in patients making almost as many inappropriate requests as appropriate ones".[7] Similarly, a 2005 systematic review of pharmaceutical DTCA benefits and harms 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", since doctors often capitulate to patient demands for the advertised drug, despite doctors' misgivings about the suitability of the drug in question.[8] A 2012 meta-analysis reinforced these findings, and concluded that "RCT and observational study evidence indicates that DTCA leads to less appropriate prescribing, in which physicians have less confidence".[9] Also, a survey of 643 randomly-selected US doctors found that they acquiesced to a DTCA-based patient request for a specific drug in 39% of the most recent visits where patients made such a request, even though in 48% of those cases where the doctor acquiesced they

---

[6] See Paul Biegler and Patrick Vargas, 'Ban the sunset? Nonpropositional content and regulation of pharmaceutical advertising', *American Journal of Bioethics* 13, no. 5, May 2013, pp. 3-13; Paul Biegler, Jeanette Kennett, Justin Oakley, and Patrick Vargas, 'Implicit persuasion and the ethics of pharmaceutical advertising', in Jens Clausen and Neil Levy (eds.) *Handbook of Neuroethics*, Dordrecht, Springer, 2015.

[7] Elizabeth Murray, Bernard Lo, Lance Pollack, Karen Donelan, and Ken Lee, 'Direct-to consumer advertising: Physicians' views of its effects on quality of care and the doctor-patient relationship', *Journal of the American Board of Family Medicine* 16, no. 6, 1 November 2003, pp. 513-24, p. 521. See also
Elizabeth Murray, Bernard Lo, Lance Pollack, Karen Donelan, and Ken Lee, 'Direct-to consumer advertising: Public perceptions of its effects on health behaviors, health care, and the doctor-patient relationship', *Journal of the American Board of Family Medicine* 17(1) Jan-Feb 2004, 6-18, Barbara Mintzes et. al., 'Influence of direct to consumer pharmaceutical advertising and patients' requests on prescribing decisions: two site cross sectional survey', *British Medical Journal* 324, 2 February 2002, pp. 278-9; Barbara Mintzes et. al., 'How does direct-to-consumer advertising (DTCA) affect prescribing? A survey in primary care environments with and without legal DTCA', *Canadian Medical Association Journal* 169, no. 5, 2 September 2003, pp. 405-12; and Richard L. Kravitz et. al., 'Influence of patients' requests for direct-to-consumer advertised anti-depressants: A randomized controlled trial', *Journal of the American Medical Association* 293, no. 16, 27 April 2005, pp. 1995-2002.

[8] S Gilbody, P Wilson, I Watt, 'Benefits and harms of direct-to-consumer advertising: A systematic review', *Quality and Safety in Health Care* 14, 2005, pp. 246-50, p. 246. The intractability of certain brand-specific preferences and requests due to the implicit persuasion techniques often used in such advertising is also likely to lead to increased levels of physician acquiescence to such requests (see Biegler et al. 2015).

[9] Barbara Mintzes. Advertising of Prescription-Only Medicines to the Public: Does Evidence of Benefit Counterbalance Harm? *Annual Review of Public Health* 2012; 33: 259-277, p. 271. See also John B. McKinlay et al., 'Effect of patient medication requests on physician prescribing behavior: Results of a factorial experiment', *Medical Care* 52, no. 4, April 2014, pp. 294-99.

regarded the requested drug as no more effective for the condition in question than other drugs – and indeed, in 5.5% of cases, the doctor prescribed the requested drug while believing that other drugs or treatment options may be *more* effective.[10] Where doctors acquiesce to clinically inappropriate medication requests, these doctors are (at least in those contexts) redefining their doctor-patient relationships as something other than therapeutic relationships, and are acting contrary to the virtue of medical beneficence here.[11]

One way in which policymakers could respond to such findings is by supporting a prohibition on direct-to-consumer-advertising of pharmaceuticals, on the grounds that allowing such advertising evidently undermines doctors' medical virtues. However, this response may be too swift, as it seems possible – and indeed, somewhat plausible – for virtue ethics to take a graduated approach to this problem. Two crucial considerations for a virtue ethics policy response here seem to be the following. Firstly, the *degree* of physician acquiescence to clinically inappropriate drug requests – for example, a 5.5% rate of such acquiescence (as mentioned above) might seem relatively low. Secondly, the prospects of success of regulatory interventions other than outright prohibitions here – for example, education and training programs could be introduced to help strengthen doctors' medical virtues so that they become more able to resist acquiescing to patients' clinically inappropriate drug requests. These considerations are clearly related, but they can also vary somewhat independently of each other, and so a matrix of possibilities emerges. A consistent virtue ethics policy line on pharmaceutical DTCA, in light of both of these considerations, could therefore be as follows. In one quadrant of this matrix, where there is evidence of *maximal* physician acquiescence, and interventions other than prohibition seem to have *little* prospect of success here, then virtue ethics could support a *prohibition* on pharmaceutical DTCA. In the diametrically opposed quadrant of this matrix, where *minimal* physician acquiescence is evident, and interventions other than prohibition seem to have *much* prospect of success here, then perhaps educational efforts to strengthen doctors' medical virtues to avoid inappropriate prescribing may be more defensible than an outright ban on pharmaceutical DTCA. Some of the doctors who acquiesced to patients' clinically inappropriate medication requests apparently did

[10] See See J.S Weissman, et al. Physicians Report on Patient Encounters Involving Direct-to-Consumer Advertising. *Health Affairs (Millwood)*. 2004 (suppl web exclusives): W4-219 – W4-233, p. W4-227. For a fascinating study of doctors' explanations of their acting against their better judgement in making these clinically inappropriate prescribing decisions, see A. Tentler et al. Factors Affecting Physicians' Responses to Patients' Requests for Antidepressants: Focus Group Study. *Journal of General and Internal Medicine* 2008; 23: 53-57.

[11] A more detailed analysis would also address the *extent* to which a doctor complying with DTCA patient requests redefines the relationship. Presumably this comes in degrees, just as we might say of a friendship – for example, a relationship is less of a friendship when someone is a fair-weather friend, but perhaps it takes further governing conditions to alter for the relationship to cease being a friendship altogether.

so because the doctors saw their acquiescing as a way of building rapport with the patient, particularly in cases where the patient suffered from a potentially stigmatizing condition, such as depression. So, education and training initiatives could be developed for doctors in legalized pharmaceutical DTCA environments, to support these doctors developing and maintaining the virtue of medical beneficence, by helping them explore alternative ways of building rapport with patients who present with these (and other) conditions.

Pharmaceutical marketing to doctors

Another well-documented way in which the therapeutic orientation of doctor-patient relationships can be undermined is through the impact of various pharmaceutical marketing activities directly upon doctors' prescribing behaviour, quite apart from whether doctors are faced with brand-specific medication requests from patients, or are inclined to acquiesce to such requests. Pharmaceutical marketing activities to doctors range from subsidised conference travel, entertainment, and other forms of hospitality, to being paid lucrative consulting fees, and doctors may consequently have various sorts of industry relationships, including the holding of shares in a pharmaceutical and/or medical device company. The distorting influences of such marketing activities directly upon doctors is a more widespread problem than is the impact of direct-to-consumer pharmaceutical advertising, as this latter form of marketing is currently allowed in only two jurisdictions – the United States and New Zealand – whereas various forms of pharmaceutical marketing aimed directly at doctors is currently permitted, and is actively pursued, in most states around the world.

Here again we can begin a virtue ethics policy analysis by asking, what does the evidence indicate is the impact of pharmaceutical marketing directed at doctors on the governing conditions of doctors' drug prescribing decisions? An influential systematic review of such marketing concluded that many of these types of physician interactions with pharmaceutical companies were associated with a greater likelihood of the doctor prescribing a drug manufactured by the company with which they have had such interactions.[12] Further, almost 1 in 5 respondents to a 2006 survey of US obstetricians and gynecologists reported that they had a personal financial interest in a pharmaceutical or medical device company.[13] And it has been reported that "as many as 59% of the authors of clinical guidelines endorsed by many [US] professional associations have had financial relationships with companies

[12] Ashley Wazana, Physicians and the pharmaceutical industry: Is a gift ever just a gift? *Journal of the American Medical Association* 283, 2000: 373-380. See also Troyen A. Brennan, David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman, Jerome P. Kassirer, Harry Kimball, James Naughton, Neil Smelser. Health industry practices that create conflicts of interest. *Journal of the American Medical Association* 295, 2006: 429-433, p. 431.
[13] M.A. Morgan, Interactions of doctors with the pharmaceutical industry. *Journal of Medical Ethics* 32, 2006: 559-563.

whose drugs might be affected by those guidelines".[14] As has been widely appreciated by policymakers and by professional medical associations, these links between doctors and pharmaceutical companies introduce conflicts of interest into drug prescribing decisions, as there is potential for doctors to be unduly influenced by these industry ties to prescribe a drug which is clinically inappropriate for the patient.[15] And, where a doctor's governing conditions in their drug prescribing decisions are diverted from being guided by their patients' best interests, to the doctor's own self-interest or the interests of a pharmaceutical company with which they have such links, then doctors are arguably transforming a therapeutic relationship with their patients into some other form of relationship, which is, perhaps, better characterized as a business or commercial relationship.

In recent years, policymakers have addressed such concerns by introducing various forms of transparency requirements, requiring doctors to report on their interactions with the pharmaceutical industry. Following the 2008 introduction of such requirements by the Cleveland Clinic for their clinicians and similar moves by various US states, the US government on 30 September 2014 launched the *Open Payments* website, which provides the public with a searchable database containing details of payments and other rewards by pharmaceutical companies to over half a million individual US doctors.[16] From a virtue ethics policy perspective, the *Open Payments* initiative seems likely to support the professional virtue of physician *honesty* in medical practice, but it will be important to investigate how such a wide-ranging form of medical transparency impacts on doctors' prescribing decisions and doctor-patient relationships, and more specifically, to see whether it supports the therapeutic orientation of those relationships. Empirical studies of such questions will then illuminate whether these more stringent transparency requirements are effective in combating clinically inappropriate prescribing, or whether they need to be supplemented by educational and training programs to strengthen virtues such as medical beneficence here – or, alternatively, whether such physician-industry payments and ties should be prohibited altogether. Thus, using the matrix of options described earlier, where there is evidence that such transparency initiatives are of limited use in curbing inappropriate prescribing, then the case for prohibiting such physician-industry ties seems to be strengthened. On the other hand, where there is evidence that such transparency initiatives *do* help to reduce inappropriate prescribing, then it would also be important to explore complementary educational programs which help support

[14] David Blumenthal, Doctors and drug companies. *New England Journal of Medicine* 351, 2004: 1885-1890, p. 1886.
[15] See Leonard J. Weber, *Profits before people? Ethical standards and the marketing of prescription drugs*, Bloomington: Indiana University Press, 2006; and Marc A.Rodwin, *Conflicts of interest and the future of medicine: The United States, France, and Japan*. New York: Oxford University Press, 2011.
[16] See *http://www.cms.gov/openpayments/*

doctors' medical beneficence, by (for example) raising doctors' awareness of, and resistance to, nontherapeutic influences on their prescribing behavior.

Indeed, there are already grounds for thinking that methods apart from these greater transparency initiatives might also be necessary to curb the distorting effects of pharmaceutical marketing to doctors on their prescribing behaviour. For evidence is emerging that the increased physician disclosure requirements which were introduced in various states before the nationwide *Open Payments* initiative have not be very effective at curtailing clinically inappropriate drug prescribing.[17] Policymakers may therefore soon turn to considering further initiatives, complementing the *Open Payments* scheme, to combat inappropriate prescribing. For example, the apparent success of offering doctors financial incentives to provide patients with more regular preventative tests (such as pap smears) in 'pay-for-performance' schemes[18] may well prompt policymakers to consider 'fighting fire with fire', by offering doctors modest financial incentives to prioritise their patients' best interests over doctors' and pharmaceutical companies' financial self-interests in their medication prescribing decisions. If such financial incentives were found to be a cost-effective way of improving doctors' prescribing behaviour, utilitarian policy approaches would presumably endorse such interventions here.[19] However, a virtue ethics policy approach could instead evaluate such proposed medication prescribing incentives by investigating the impact of other financial incentive schemes in medicine on the therapeutic orientation of doctor-patient relationships, and thus, on doctors' medical virtues. Consider, for example, the introduction in 2004 of financial incentives for UK family practitioners to better manage patients with asthma and type-2 diabetes, which evidently led to improvements in health outcomes for those practitioners' patients with those conditions.[20] These reactions of many UK family practitioners to the introduction of such financial incentives seem to reveal something about the nature of their relationships with patients, for those practitioners who responded to such incentives by better managing their patients with asthma, heart disease and diabetes might have done so at the cost of transforming their relationships with those patients from therapeutic to commercial relationships. Where doctors involved in such schemes are evidently serving their patients' best interests only on condition of being paid additional financial incentives to do so, those doctors have arguably redefined the therapeutic

[17] See eg. Marc A.Rodwin, *Conflicts of interest and the future of medicine: The United States, France, and Japan*. New York: Oxford University Press, 2011, pp. 215-19; and Genevieve Pham-Kanter, G. Caleb Alexander, and Kavita Nair. Effect of physician payment sunshine laws on prescribing. *Archives of Internal Medicine* 172, 2012: 819-821.
[18] See Rodwin op. cit, pp. 16-20; Stephen Campbell, David Reeves, Evangelos Kontopantelis, Elizabeth Middleton, Bonnie Sibbald, and Martin Roland. 2007. Quality of primary care in England with the introduction of pay for performance. *New England Journal of Medicine* 357: 181-190.
[19] See eg. Robert E. Goodin, *Utilitarianism as a Public Philosophy*. Cambridge: Cambridge University Press, 1995.
[20] See Campbell et al. op. cit.

nature of their doctor-patient relationships as commercial relationships.[21] On a virtue ethics policy approach, this would be too high a moral cost for us to pay in improving health outcomes.

Other initiatives for supporting medical virtues

Of course, in order to be effective, any regulatory intervention into medical conflicts of interest must be accompanied by educational initiatives, particularly at the Continuing Professional Development (CPD) stage. As Marc Rodwin has argued, "Whatever institutions and rules society uses to cope with conflicts of interest will be more effective if physicians not only respect them but are also guided by an ethos of public service, fidelity to patients, and commitments to knowledge and excellence."[22] Thus, a more comprehensive approach to supporting therapeutic relationships and thus medical virtues would draw on an analysis of empirical research on the impact of current CPD approaches to addressing medical conflicts of interest, along with emerging initiatives. For example, Dubovsky and colleagues have demonstrated that assisting medical graduates to understand and better evaluate various pharmaceutical marketing techniques that they are exposed to raises their awareness of inappropriate influences on their prescribing behaviour.[23]

Also, a number of studies have indicated that poor role models in the health care workplace are major factors in determining whether medical graduates act on the ethical principles taught to undergraduates.[24] It appears that some clinicians continue to regard ethical analysis of decisions as pointless, believing that ethics is too time consuming, is an entirely subjective matter, or that there are "no right answers" anyway. The corrosive influence of such clinicians on medical graduates is commonly referred to as the "hidden curriculum" in medicine. Frederic Hafferty and Ronald Franks coined the term the 'hidden curriculum' to describe a powerful institutional culture, which subverts the fundamental ideals of medical ethics: "Medical training is not just learning about becoming a physician, it involves learning how to 'cease' to be a lay person. …It is during medical training…that students learn to establish the primacy of individual experience along with the 'dangers' of becoming 'too'

[21] See Justin Oakley, 'Sketch of a virtue ethics regulatory model: Response to commentaries' (response to Tom Beauchamp, Alastair Campbell, Masatoshi Nara, and Ilhak Lee), in Akira Akabayashi (ed.), *The Future of Bioethics: International Dialogues*, Oxford, Oxford University Press, 2014, pp. 697-702.
[22] Rodwin, op. cit., p. 231.
[23] See S.L. Dubovsky, et al. 'Can academic departments maintain industry relationships while promoting physician professionalism?' *Academic Medicine* 85, no. 1, January 2010, 68-73.
[24] See eg. Steve Bolsin, Tom Faunce, and Justin Oakley, 'Practical Virtue Ethics: Healthcare whistleblowing and portable digital technology', *Journal of Medical Ethics* 31, no. 10, October 2005, pp. 612-18.

involved, 'too' reflective, or 'too' introspective."[25] A subsequent study by John Goldie and colleagues also suggest the persistence of such a phenomenon. Goldie and colleagues found that when medical students were asked whether they would report on a corrupt colleague, the number who would report the unethical behaviour *declined* during the medical course, from a high of 13% in the early weeks, to a low of less than 5% in the last weeks of training, after the students had gained some practical experience in various health care environments.[26]

So, how might medical professionals become more ethically resilient in the face of contrary influences? Innovative experiential approaches to teaching medical ethics developed by Thomas Faunce at the Australian National University and Dr Stephen Bolsin, a whistleblower from the Bristol Royal Infirmary who is now at Geelong Hospital, have had considerable success in helping medical graduates to counter the hidden curriculum. Medical students learn directly from individuals who have expressed professional integrity in blowing the whistle on colleagues' unethical behaviour. Students are then immersed in a simulated whistleblowing situation over an extended period of time, and they experience how it feels to report on corrupt colleagues, and what the consequences of such actions can be, for themselves and others. Adding such experiential elements to the teaching of medical ethics seems to be a promising way of helping to provide medical graduates with the resilience they need to resist the influence of negative role models in the workplace.

Conclusion

A plausible evidence-based virtue ethics approach to public policy in the context of regulating professional behaviour can be developed by focusing on the impact of a certain policy initiative on the proper orientation of professional relationships between practitioners and clients/patients. I have discussed direct and indirect influences of pharmaceutical marketing on doctors' prescribing behaviour to illustrate how the nature of doctor-patient relationships can reveal the presence or absence of medical virtue in doctors. It follows from the virtue ethics policy approach outlined here that the state must help to create regulatory environments which support practitioners' efforts to maintain the sorts of professional relationships with patients and clients – and thus, the relevant professional role virtues – which they agreed to have when they joined the profession.

---

[25] Frederic W. Hafferty and Ronald Franks, 'The hidden curriculum, ethics teaching, and the structure of medical education', *Academic Medicine* 69, no. 11, November 1994, pp. 861-71, at pp. 865-6.

[26] John Goldie, Lisa Schwartz, Alex McConnachie, Jillian Morrison, 'Students' attitudes and potential behaviour with regard to whistleblowing as they pass through a modern medical curriculum', *Medical Education* 37, no. 4, April 2003, pp. 368–75.