A Humble Task: Restoring Virtue in an Age of Conflicted Interests
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Abstract
Virtues define how we behave when no one else is watching; accordingly, they serve as a bedrock for professional self-regulation, particularly at the level of the individual physician. From the time of William Osler through the end of the 20th century, physician virtue was viewed as an important safeguard for patients and research participants. However, the Institute of Medicine, Association of American Medical Colleges, and other policy groups—relying on social science data indicating that ethical decisions often result from unconscious and biased processes, particularly in the face of financial conflicts of interest—have increasingly rejected physician virtue as an important safeguard for patients.

The authors argue that virtue is still needed in medicine—at least as a supplement to regulatory solutions (such as mandatory disclosures). For example, although rarely treated as a reportable conflict of interest, standard fee-for-service medicine can present motives to prioritize self-interest or institutional interests over patient interests. Because conflicts of interest broadly construed are ubiquitous, physician self-regulation (or professional virtue) is still needed. Therefore, the authors explore three strategies that physicians can adopt to minimize the influence of self-serving biases when making medical business ethics decisions. They further argue that humility must serve as a crowning virtue—not a meek humility but, rather, a courageous willingness to recognize one's own limitations and one's need to use “compensating strategies,” such as time-outs and consultation with more objective others, when making decisions in the face of conflicting interests.

In 1966, after reviewing a series of unethical medical experiments conducted with human subjects, the prominent Harvard physician Henry Beecher concluded that there are two primary protections in research: informed consent and “the more reliable safeguard provided by the presence of an intelligent, conscientious, compassionate, responsible investigator.”

Virtues in Medicine: A Romantic Notion Dispelled by Science?
In recent years, through a series of reports and policy decisions, the place of virtue in medicine has been questioned—not so much on theoretical grounds as on empirical grounds. It is the notion that virtues are “dispositions” that has fallen under the most suspicion. Virtue theorists such as Aristotle and Pellegrino never thought that virtuous people are automatons: They act voluntarily and they are capable of error. Thus, virtuous physicians may not always behave in ways that maximally promote a healing relationship. Nevertheless, if physicians have a virtuous disposition, one would expect them to act virtuously in a fairly consistent manner across a variety of environmental situations. In contrast, a series of social science experiments indicate that humans in general are not consistent in their behavior. Ethical decisions are affected by how things are framed, whether we are observed, and even by seemingly trivial environmental factors such as scents in the air. More worrisome is evidence that to the extent that individuals are consistent, they appear to be consistent in acting on a self-serving bias rather than on self-effacement. Finally, data indicate that individuals often arrive at their moral judgments through intuition, which is highly susceptible to the influence of bias; reasoning is frequently used only to justify judgments arrived at intuitively.

A review of social science data by Dana and Loewenstein suggests that
physicians are not immune from these dynamics.

In response to such data, many organizations—including the Institute of Medicine (IOM) and the Association of American Medical Colleges (AAMC)—appear to have rejected the notion of relying on physician virtue as a safeguard of participants and patients, particularly in the face of financial conflicts of interest.14,15 The IOM Report Conflict of Interest in Medical Research, Education, and Practice14(p343) observes that “some research suggests that small gifts can contribute to unconscious bias in decision making and advice giving.” The report included an appendix, “How psychological research can inform policies for dealing with conflicts of interest in medicine,” that focuses on the self-serving bias described in the following terms:

… research shows that when individuals stand to gain by reaching a particular conclusion, they tend to unconsciously and unintentionally weigh evidence in a biased fashion that favors that conclusion. Furthermore, the process of weighing evidence can happen beneath the individual’s level of awareness, such that a biased individual will sincerely claim objectivity.14(pp358–359)

Similarly, when the AAMC’s Task Force on Industry Funding of Medical Education issued its report16 in 2008, it was preceded by a 43-page document, “The Scientific Basis of Influence and Reciprocity: A Symposium,”16(p6) which explored data from neuroscience, psychology, and behavioral economics on the influence of conflicts of interest on physicians. As with the IOM report, a prominent conclusion was that “self-interest unconsciously biases well-intended people, who give themselves bounded ‘moral wiggle room’ to engage in unethical behavior with an easy conscience.”16(p5) This unconscious nature of self-serving bias, noted in both reports, helps to explain why most physicians believe that their colleagues are influenced by industry marketing although they themselves are not.17

The shift from prudence to public policy
The IOM and the AAMC reports both offer broad-ranging policy recommendations in response to the potentially toxic combination of financial conflicts of interest and physician (really, human) self-serving bias. Consistent with some of these recommendations, the Physician Payments Sunshine Provisions of America’s Affordable Health Choices Act of 2009 (H.R. 3200) requires U.S. drug and device manufacturers covered under Medicare, Medicaid, or the State Children’s Health Insurance Plan to report annually a broad array of payments to physicians, including payments for consulting and service, honoraria, gifts, food, entertainment, and support for education and research, thus ushering in a new era of transparency and accountability that bypasses the need to rely on physician disclosures.

Concessions and challenges
In this article, we do not contest data indicating that humans frequently act in ways that are unconsciously self-serving. Nor do we contest the wisdom of having some policies to guide the financial relationships of physicians; Such policies were developed in response to real abuses of relationships.18 Rather, we argue the following:

• A persistent need for physician virtue and self-regulation exists; external regulations alone cannot adequately address conflicts of interest, which are ubiquitous.
• Several habits can increase the likelihood that physicians will act in virtuous ways, that is, ways that promote the primary goals of medicine even when these goals conflict with maximizing physicians’ financial self-interest.
• Physicians require the virtue of humility (understood as self-knowledge and an openness to the perspective of others rather than as meekness) to support use of the habits, or “compensatory strategies,” that will enable physicians to prioritize the goals of medicine over their own self-interest.

Conflicts of interest are ubiquitous
Only a small subset of financial conflicts of interest is readily identifiable and easily controlled through oversight. Many of the worst financial crimes in medicine have occurred through simple fee-for-service mechanisms rather than as entanglements with industry.19–21 And not only industry, but also patient advocacy groups, hospitals, insurers, and state and federal governments try to influence physician behavior (e.g., prescribing and referral patterns), threatening the objectivity and beneficence of physicians’ judgments.22,23

A recent set of stories by physicians on financial relationships24 described the following: A practice manager who reported weekly on physicians’ relative value units while encouraging the physicians to order more tests; a hospital CEO who required physicians to take calls from an inappropriately broad catchment area to increase enrollment in his tertiary care center; and physicians in a practice who continued to perform expensive invasive cardiac procedures when medical management was better supported by the evidence. In each case, physicians’ own self-interest might be viewed as satisfying their business partners to increase earnings and maintain job security—That is, in principle, the dynamic of self-serving bias might be activated in these situations every bit as much as in a situation involving a relationship with industry. Yet none of these scenarios requires disclosure or management under current conflict-of-interest policies, nor is it clear that disclosures are necessary, as it seems well known by patients that physicians bill for services and work for hospitals.

Current policy solutions have limitations
Policy-based oversight systems have significant limitations: Loopholes are inevitably found. Identifying these loopholes takes time (enabling abuses to occur), and closing them requires new layers of administrative burden.24,25 Current conflict-of-interest policies rely on self-reporting, yet physicians often interpret the rules differently, enforcement is inconsistent, and compliance is spotty.26–28 Further, administrative solutions to conflicts of interest may be ineffective: Some evidence suggests that disclosure—the
most commonly mandated management strategy for conflicts of interest—may exacerbate rather than reduce problems with conflicted judgment.29 Finally, rule-based approaches to changing behavior tend to work best when behaviors are readily observed and rules are readily enforced,30 yet this is extremely difficult to accomplish in regard to the many forms of conflicts of interest in medicine—much more difficult than, say, enforcing motorcycle helmet or traffic light laws.31,32

Finally, nothing good can come of the message to physicians that “we assume you will behave selfishly when dealing with patients.” Cynicism itself is a predictor of unethical decision making.9,33

One of the main conclusions of the IOM report was precisely that “if medical institutions do not act voluntarily to strengthen their conflict-of-interest policies and procedures, the pressure for external regulation is likely to increase.”14(p2) Pellegrino3 has argued similarly, however, appealing to individual rather than institutional virtue: “If the freedom to be creative about clinical healing as well as scientific research is abused, all physicians and scientists are morally diminished and society may justly intervene.”

So can anything be done to foster virtues in a manner that is not merely naive and romantic, but responsive to the very psychological data that challenge the existence of virtues?

Three Habits for Promoting Consistently Professional Behavior

As noted above, current data indicate three problems for the adoption of virtue as a safeguard: (1) many ethical decisions are the result of automatic rather than deliberative processes, (2) when running on autopilot, self-serving biases operate, and (3) self-serving biases operate unconsciously and, thus, beyond the realm of “willpower.” What would it look like if, in response to these troubling data, physicians attempted to engineer their own behavior to minimize the effects of self-serving bias and to maximize the likelihood of acting in accordance with the aims of medicine? Data suggest that the following three habits, or compensatory strategies, might facilitate acting in accordance with virtues in medicine.

Reflecting—the use of ethics “time-outs”

The World Health Organization and other groups advocate the use of a “time-out” in surgery to reduce preventable errors.34 Time-outs are pauses taken to ask a series of questions, usually guided by a checklist. For example, the WHO time-out checklist involves asking questions about the identity of the patient, the surgical site, and the procedure, as well as less obvious questions such as:

- What are the critical or unexpected steps, operative durations, anticipated blood loss?
- Are there any patient-specific concerns?
- Has sterility (including indicator results) been confirmed?34

Similarly, in an attempt to avoid preventable lapses of professionalism, physicians might take an “ethics time-out” whenever entering into new financial relationships. For example, before agreeing to join a speaker’s bureau, accepting a particular form of insurance, or accepting payments to enroll patients in a clinical trial, physicians might ask questions such as:

- Will this relationship benefit my patients?
- Would I be comfortable with my patients’ knowing details of this relationship?
- If this relationship poses any risk of compromising patient care, can these risks be identified and managed? Am I willing to establish and cooperate with appropriate oversight?
- Do I need to recuse myself from any roles or decisions?
- Do I invite critical feedback from colleagues and subordinates such that problems might be identified and addressed early?

Social learning and developmental psychologists indicate that people can and do, in fact, engage in such reflection with some regularity and that it can lead to improved decision making.29,35,36 But, just as with surgical time-outs, such practices are most likely to be effective when they are used routinely.

Consulting with “objective” others

In a lengthy review article, Mercier and Sperber3 examine data showing that even when we pause to reflect and reason—apparently bypassing the automatic processes responsible for many self-serving judgments—our reasoning is still subject to a series of biases (such as bolstering and confirmation bias) that increase the likelihood we will produce arguments in support of conclusions we already support intuitively or are motivated to support. Thus, reflection and reasoning are unlikely to solve all problems of bias. Nevertheless, data indicate that group discussion of arguments often leads to the production of more satisfactory arguments—first, because people are better at evaluating argument than producing sound arguments, and, second, because people are more likely to reject the arguments of others, which serves to filter arguments.6 Moreover, consulting others provides us with a sense of how our actions will be perceived, and we naturally aim to protect our reputations.12

From this perspective, ethics committee members, institutional review boards, and ethics consultants may be in an ideal position to provide such feedback—not so much because they possess special expertise in ethics as that they are typically in a good position to provide an “outsider” perspective and to highlight the values and concerns others might have. Although it might not be feasible to invite a consultation on every business decision, it should be automatic to consult with others whenever we encounter the sort of “flag” that often precedes bad decisions—for instance, if we have reservations, if others have expressed criticism of the arrangement, or if we believe the decision has the potential to be controversial.

Automating ethical choices

Individuals who are committed to virtue have long structured their lives to facilitate good actions rather than relying on willpower. For example, it may be easier to avoid eating potato chips if they are not brought into the house. (Celibate monks and nuns frequently cloistered themselves for analogous reasons.) Many of the policies that the AAMC and IOM have recommended regarding relationships with industry are sensible insofar as they reduce the
opportunities to prioritize financial gain over fiduciary obligations to patients. However, a shortage of government research funding may make collaboration with industry a near necessity, and most practicing physicians are not subject to AAMC guidelines. Moreover, any set of guidelines leaves many issues unaddressed. We therefore encourage physicians to voluntarily structure their own lives in ways that reduce the need to rely on reflection and willpower in individual situations. Developing “personal policies” based on one’s own reflected values may reduce the need for governments and institutions to regulate all dimensions of medical practice.

Consider two examples, which we have culled from the sources cited:

In trials that involve a medication-free arm, a psychiatrist–principal investigator has another member of the research team obtain consent from her own patients. She knows that some patients confuse participation in a research trial with individualized therapy (the so-called therapeutic misconception) and she knows that her attitudes toward clinical trials deeply influence their decisions.27,38

After reading that pharmaceutical companies sometimes spend 50% of their marketing budget on free samples and that free samples increase the likelihood of prescribing a drug patients cannot afford, an internist in a small private practice decides not to accept free samples.39,40

As these examples illustrate, not every physician will agree with these personal policies—Ethics often involves balancing competing principles and goods. Yet, such policies may well serve physicians who have learned to question their own integrity in specific situations.

Humility as a Prerequisite Virtue
It is humbling to think that physicians sometimes make (even unconsciously) patient care decisions that are more consistent with their own financial welfare than their patients’ medical needs. It is humbling to forego making a decision until we have time to ask colleagues, patients, or others to share their perceptions and wisdom, or to structure our lives to reduce the need to rely on virtue in specific situations when we may not be at our best.

Humility: A thoroughly modern virtue
It is thus not surprising that the virtue of humility has been appreciated as essential to good practice since the inception of the modern era of medicine. In 1892, during an address to medical students at the University of Minnesota, Sir William Osler urged his audience, “at the outset of your journey take the reed of humility in your hands, in token that you appreciate the length of the way, the difficulties to overcome, and the fallibility of the faculties upon which you depend.”21(p38) In words that describe our current context surprisingly well, he adds:

In these days of aggressive self-assertion, when the stress of competition is so keen and the desire to make the most of oneself so universal, it may seem a little old-fashioned to preach the necessity of virtue but I insist of its own sake … since with it comes not only reverence for truth, but also proper estimation of the difficulties encountered in our search for it … This grace of humility is a precious gift.22(p36)

Three qualities required for humility
A contemporary understanding of humility has been offered by Coulehan,41 who proposes that humility requires three qualities:

• “Unflinching self-awareness”—an ability to know your own strengths as well as a willingness to confront your weaknesses.

• “Empathetic openness to others,” manifested by good listening skills and the ability to be present to the needs of others.

• “A keen appreciation of, and gratitude for, the privilege of caring for sick persons.”

The first two of these qualities clearly support the very habits we recommend as a remedy for the self-serving bias that has called the very possibility of virtue into question: acknowledging our tendency toward biased decision making, practicing reflection, and soliciting input from respected others precisely in order to ensure that we protect our commitment to serving patients before ourselves. The third quality suggests an even more fundamental habit: Recalling the fundamental goals of medicine.

As noted above, according to Pellegrino and Thomasma the virtues of a profession are those traits of character that enable individuals to achieve the goals of the profession. No strategies or habits—such as taking time-outs or consulting with others—will serve to support virtue if a professional is not first committed to the primary goals of the profession. In medicine, the primary goal is patient care focused on prevention, healing, and palliation (with personal or corporate profit and prestige as merely secondary goals).42

Limitations to Our Solutions
Engaging the central role of goals in professional virtue, Goodpaster43 defines teleopathy as the unbalanced pursuit of purpose or goals. In business, this may manifest as a pursuit of profits without proper consideration of means or other important purposes such as providing a good product.

This article has little to offer to physicians who suffer from teleopathy. We assume that physicians pursue many purposes through their activities—earning a living, developing medical knowledge, and training new physicians. But we also assume that these goals are secondary to patient care and that the means of achieving these goals matter. Physicians who pursue personal gain as a primary aim of the practice of medicine will not profit from the habits proposed in this article because those habits are all aimed at overcoming self-serving bias. However, physicians who are committed to prioritizing the well-being of their patients in their practice of medicine or their medical research may find that these habits increase the likelihood of acting virtuously. We understand this to mean acting more consistently in accord with the moral values one embraces as a physician rather than out of the unenlightened self-interest that apparently drives much of our decision making when we naively trust ourselves to do the right thing without adequate supports in place. In this discussion, we have not provided an account of how virtues such as prudence originate (e.g., through modeling and character formation) but, rather, an account of how individuals may increase the likelihood of acting in virtuous ways even when the environment poses challenges to their trained character.

Conclusions
On the one hand, we understand why oversight bodies and professional associations have begun to heavily
regulate specific kinds of conflicts of interest. On the other hand, we consider it deeply troubling that major reports such as those of the IOM and AAMC would completely fail to encourage reliance on physician virtue as at least part of the solution. It is folly to imagine that regulators can identify and remedy all forms of unprofessional behavior, particularly if the self-serving bias is as strong as some oversight bodies believe it to be. Policies—and especially educational programs for physicians, residents, and medical students—need to remind people of the primary goals of medicine. Attending physicians and institutions need to model decisions that prioritize patient interests. And medical ethics courses need to go beyond teaching the skills and habits that enable physicians to act in accord with the goals of medicine even when confronted with fatigue, strong personal rewards, and other challenges to integrity.

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References