Creating regulatory environments for practical wisdom and role virtues in medical practice

Justin Oakley
Associate Professor,
Monash University

A number of philosophers have recently provided more empirically-informed accounts of virtue and virtue ethics, according to which acting virtuously requires, among other things, the development of certain deliberative strategies to counter common decision-making biases and other countervailing factors which can impede virtuous action. These accounts employ a comprehensive conception of virtuous character-traits, whereby practically intelligent virtues include an awareness of situational factors which conduce to or inhibit virtuous behaviour. In this paper I argue that in the context of professional life, these personal strategies for facilitating virtuous behaviour should be supported by the development of regulatory environments which assist practitioners acting from the relevant professional dispositions to hit the targets of those virtues.

Taking medical practice as an example, I discuss two important ways in which policymakers and regulators can help to successfully enable virtuous practitioner behaviour in professional contexts. First, policymakers and regulators should aim to create institutional environments that raise practitioners' awareness of common biases in clinical practice – such as availability bias and confirmation bias in diagnosis – and which also help practitioners to avoid biases diverting medical role virtues from their targets. Second, when evaluating an existing or proposed policy which has some independent rationale, policymakers should also consider the position doctors may be put in by this policy – such as whether the policy threatens to undermine therapeutic doctor-patient relationships, along with action from the virtue of medical beneficence. For instance, policies allowing advertising of prescription pharmaceuticals directly to consumers increase patient requests for clinically inappropriate medications, and some doctors working in such institutional environments evidently find it difficult to resist acquiescing to those requests. Yet medical acquiescence in such circumstances is contrary to therapeutic doctor-patient relationships, and to the role virtue of medical beneficence. While policymakers might assist doctors to develop deliberative strategies to better manage such requests, a more defensible policy approach where such requests are highly prevalent might be to abandon altogether a policy of allowing such advertising. I also discuss how similar concerns are raised by certain institutional incentives which have the unintended consequence of encouraging hospitals and doctors to agree to requests from patients' families to provide interventions to a dying relative, even when those interventions are futile. In considering these examples, I also aim to clarify the links between professional role virtues and properly-oriented practitioner-patient and professional-client relationships.

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- 使用言語:英語
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