Physicians give advice. That’s what we do.

In doing so, we are required to be unbiased advocates for our patients. We are fiduciaries, to use a term from economics. [1] Life and death issues, especially end of life issues, heighten the gravitas of these moments; and often in those times guidance comes from the family as well as physicians.

Jason Dana and Daylian Cain authored a meta-analysis, Advice versus Choice [1], that shows the ways that advice given by physicians is biased, intentionally or not. Or as they put it, “A fundamental ethical principle is that we should treat others as we ought to be treated. Yet, what people advise others to do is often different than what they choose for themselves.” The paper looked at studies exploring our choices versus our advice.

Here is what they found:

- Decision makers are more risk adverse in choosing for others, but primarily in situations where there is a potential for loss. As they write, “Advisors feel your pain, not your gain.”

They consider that this may be due to a cognitive bias – that we are more empathetic about someone’s loss than their gain. We are more sensitive to loss. They also note that decision makers usually rely on one factor out of many in giving advice and that this frequently differs from the weighting or priorities of advice seeker. [2]
And one would think that accountability for your advice would be helpful in focusing your efforts on being a good fiduciary. And accountability will make you more deliberative, and that is good. But another cognitive bias intervenes in the setting of heightened accountability.

- Accountability exacerbates aversion to loss and promotes maintenance of the status quo.
- These bias toward conservative behavior also shields one from blame.

Or as the author's quote, “We rarely hear stories of people who are irresponsibly risk-averse for others.” [3] Advice is a social behavior, part of being social creatures. Our sociability also impacts the advice we give.

- People remember actions that resulted in a loss more strongly than those actions leading to a gain; it is often in the best interest of maintaining a relationship to give more conservative, loss-adverse advice. The exception to this generality is when taking risk may be more socially acceptable e.g. encouraging a reluctant friend to go on a blind date.

Finally, they note that being aware of these biases and conflicts of interest do not necessarily aid us in listening to advice. Physicians, especially those that do procedures and surgery are paid for doing more and unintentional, and unconscious self-serving bias may impact their advice.

Advice-seekers may already recognize this bias and overcompensate, rejecting advice that they would have chosen on their own. (This is one source of the desire for second opinions) Paradoxically, acknowledging this conflict does not necessarily improve the situation as advisers may embellish/exaggerate their opinions knowing they will be discounted and believing that having identified their conflict of interest, the person has been “warned.” They authors end with two pieces of advice,

- “Ironically, advisees might be wise to reduce accountability pressures on advisers. For example, instead of asking an advisor, ‘What should I do?’ it might be better to ask, ‘What would you do?’” [4]
- "Further, to reduce pressure to comply with biased advice, advisees may want to reduce accountability pressures on themselves, e.g., by deciding during a cooling-off period away from the prying eyes of interested advisors.”

Much of their description of advisory behavior rings ‘true’ from my experience as a physician, I just wonder why they didn’t mention it during my training and more importantly, do physicians in training learn about the social behavior around giving advice now?

Notes
[1] A fiduciary relationship requires loyalty and reasonable care of the assets of another without regard to the effect on the agent. All actions are to be performed for the advantage of the beneficiary.

[2] This can be especially true when physicians deal with the elderly who have very different goals for their health than does a 40 to 50-year-old doctor.
[3] This is not always borne out in malpractice litigation where delay in diagnosis remains a frequent source of concern.

[4] Often the physician hears this as 'what would you do if this was your mother?'