

Deception, intention and clinical practice

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ABSTRACT

Regarding the appropriateness of deception in clinical practice, two (apparently conflicting) claims are often emphasised. First, that ‘clinicians should not deceive their patients.’ Second, that deception is sometimes ‘in a patient’s best interest.’ Recently, Hardman has worked towards resolving this conflict by exploring ways in which deceptive and non-deceptive practices extend beyond consideration of patients’ beliefs. In short, some practices only seem deceptive because of the (common) assumption that non-deceptive care is solely aimed at fostering true beliefs. Non-deceptive care, however, relates to patients’ non-doxastic attitudes in important ways as well. As such, Hardman suggests that by focusing on belief alone, we sometimes misidentify non-deceptive care as ‘deceptive’. Further, once we consider patients’ beliefs and non-doxastic attitudes, identifying cases of deception becomes more difficult than it may seem. In this essay, I argue that Hardman’s reasoning contains at least three serious flaws. First, his account of deception is underdeveloped, as it does not state whether deception must be intentional. The problem is that if intention is not required, absurd results follow. Alternatively, if intention is required, then identifying cases of deception will be much easier (in principle) than Hardman suggests. Second, Hardman mischaracterises the ‘inverse’ of deceptive care. Doing so leads to the mistaken conclusion that common conceptions of non-deceptive care are unjustifiably narrow. Third, Hardman fails to adequately separate questions about deception from questions about normativity. By addressing these issues, however, we can preserve some of Hardman’s most important insights, although in a much simpler, more principled way.

HARDMAN’S ACCOUNT OF DECEPTIVE CARE AND NON-DECEPTIVE CARE

According to Hardman, deception in clinical practice ‘involves introducing or sustaining a patient’s false or erroneous belief about their condition or treatment’.¹ Further, it is ‘commonly held

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that non-deceptive care is the ‘inverse’ of deceptive care. If so, then non-deceptive care (seemingly) involves ‘introducing or sustaining a patient’s true belief about their condition or treatment’.¹ The problem, Hardman argues, is that there are other ways of engaging in ‘non-deceptive care’. These other ways become clear when considering ‘non-doxastic attitudes such as hope and pretence’.¹ Regarding pretence, sometimes it is enough that physicians ‘act as if’ a treatment is effective in order ‘to enact an efficacious treatment context and promote therapeutic effect’.¹ For instance, a physician may act ‘as if [a treatment] is more straightforwardly effective than evidence suggests’.¹ This, Hardman suggests, is not obviously deceptive. It may simply demonstrate ‘care, tact and empathetic understanding’ of a patient’s ‘clinical need’.¹ Engaging in pretence, therefore, does not automatically entail deception.

Hardman’s insights are valuable, but three problems arise here. First, Hardman’s account of deception says nothing about intention. If intention is not required for deception, then Hardman’s account of deception is implausible. Alternatively, if intention is required for deception, then identifying deceptive practices is easier (in principle) than Hardman suggests. Second, when criticising the ‘common’ view that non-deceptive care is the ‘inverse’ of deceptive care, Hardman mischaracterises the inverse of deceptive care. Third, Hardman fails to distinguish questions of deception from questions of normativity. Acting with care, tact and empathy does not imply that one’s actions are non-deceptive. Fortunately, once we fine-tune Hardman’s account of ‘deceptive care’—and once we identify its true inverse—we can capture Hardman’s central insights, although in a simpler and more principled way.

DECEPTION REQUIRES INTENTION

For Hardman, deception in medicine ‘involves introducing or sustaining a patient’s false or erroneous belief’.¹ Does deception require the intention to do this? It seems Hardman suggests not. In one case, he imagines an acupuncturist who ‘genuinely believes’ that her patient’s back pain is ‘caused by the disruption of’ his ‘vital energy’.¹ Yet, Hardman supposes,

her belief is based on ‘research that, by the standards of modern medicine, is not credible’.¹ Hence, Hardman suggests, ‘although [the acupuncturist] believes what she is saying, one could argue that she is unintentionally attempting to deceive’¹ her patient.¹ So, for Hardman, deception may not require intention.ⁱⁱ This view has absurd implications.

To illustrate, imagine that during a clinical encounter, a patient with type 2 diabetes believes this: if this physician says I need to monitor my blood sugar, then that just proves my belief that all physicians are pawns for Big Pharma. Unsurprisingly, the physician eventually tells the patient, ‘you need to monitor your blood sugar.’ In saying this, the physician has sustained the patient’s erroneous belief that all physicians are pawns for Big Pharma. So, on Hardman’s account (sans intention), the physician has deceived the patient. That is, even if physicians communicate plainly, speak truthfully, and base their claims on the best available evidence, their utterances may still count as deceptive. This places the bar for providing ‘non-deceptive care’ impossibly high.ⁱⁱⁱ If deception in medicine involves intentionally ‘introducing or sustaining a patient’s false or erroneous belief,’ however, the problem dissolves. So, we have good reason to posit that deception requires intention.

IDENTIFYING DECEPTION: EASIER THAN EXPECTED

If deception requires intention, then it becomes easier (in principle) to identify cases of deception than Hardman supposes. To illustrate, consider a case, based on Hardman’s own case:

1. A patient requests antibiotics, but her physician is unsure whether she has a bacterial infection or viral infection. Imagine two variations of this case. First (1a), the physician obliges with no argument or explanation, solely to save time. Second (1b), the patient ‘thinks she

ⁱI will set aside the worry that ‘unintentionally attempting’ is a contradiction in terms. Legally, for instance, an attempt to commit a crime is defined, in part, as ‘an act, done with intent...’.²

ⁱⁱOn Hardman’s view, even if the acupuncturist is ‘unintentionally attempting to deceive’ the patient, it does not follow that she will judge her actions to be deceptive. That is, she may think there is nothing deceptive about her actions.

ⁱⁱⁱTo be clear, physicians may accidentally mislead their patients. But, as Carson has argued, accidental misleading is different from deceiving.³

has a bacterial infection,' the physician disagrees, the physician also explains his view, and then prescribes antibiotics with the caveat that the patient should take them only if her condition worsens.

In either version, does the physician deceive the patient? In principle, we can discern clear answers.

Following Hardman's descriptions, in case 1a, the physician is indifferent to the patient's beliefs.¹ If the physician intends that his actions introduce (or sustain) the patient's false beliefs, then he acts deceptively. If he does not intend this, then he does not engage in deception. That does not imply that the physician is epistemically (or morally) blameless, however. If the physician does not care about the truth of the matter—and further, does not care what the patient believes—then he is likely engaged in bullshitting. As Miller puts the distinction, 'the bullshitter does not intend to deceive others or get them to believe false things' but instead, just lacks any real 'concern with truth'.² What the bullshitter cares about, primarily, is whatever is 'expedient in serving (their) agenda'.³ Indeed, the physician in case 1a pursues expedience over truth; he acts as he does, Hardman states, 'so he can go home at a reasonable hour'.¹ The upshot is that physicians may engage in epistemically (or morally) questionable behaviour—as related to a lack of concern about their patients' false beliefs—even if they are not deceiving patients. The dichotomy of 'deceptive' versus 'non-deceptive' care, in other words, is just one way to look at things. There is a much richer taxonomy of epistemic (and moral) vice to draw on when identifying the kind (and character) of physicians' actions.

Returning to case 1b, does the physician intend that his patient form (or sustain) some false belief(s)? If not, then deception does not occur. Based on Hardman's description, the physician does not intend to mislead. Still, Hardman baulks here. He writes, 'it does not seem right to describe [the physician's] practice as deceptive' while, simultaneously, 'a judgement of deception remains underdetermined'.¹ The former claim is correct. The latter claim confuses deception with other epistemic issues. As noted above, since there is no intention to introduce (or sustain) false belief(s), deception does not occur. If, despite providing non-deceptive care, the patient still clings to her false beliefs, then something else has gone awry. The physician might inadvertently mislead the patient, the patient might be epistemically irresponsible in a variety of ways, etc. We likely need more information.

Critically, even if identifying the nature of the problem in case 1b is difficult (or requires more information), that does not mean that it is difficult to answer the question of whether deception has occurred. That question remains easy to answer (in principle).

IDENTIFYING THE ACTUAL INVERSE OF DECEPTIVE CARE

Setting aside intention (momentarily), another problem arises. Hardman claims that commonly, non-deceptive care is taken to be the 'inverse' of deceptive care. Since deceptive care 'involves introducing or sustaining a patient's false' beliefs, it (seemingly) follows that non-deceptive care involves 'introducing or sustaining a patient's true' beliefs.¹ Hardman argues that this account of 'non-deceptive care' is too narrow; it excludes genuine cases of non-deceptive care.

Hardman may be right. The problem is that this account is not actually the inverse of 'deceptive care'. Instead, the inverse (understood, 'negation') of deceptive care is this: Neither introducing nor sustaining a patient's false beliefs. Naturally, one way to avoid introducing (or sustaining) false beliefs is to introduce and help patients sustain true beliefs. But there are other ways as well. Does this account of 'non-deceptive care'—the actual inverse of deceptive care—leave room for the cases of non-deceptive care that Hardman claims are unjustifiably excluded by the 'common' view? Yes. Pretence, for example, need not introduce false beliefs. Nor must it involve the sustaining of false beliefs. To illustrate, consider a case^{iv}:

2. A patient with back pain tries acupuncture. The acupuncturist states—though does not believe—that the patient's pain is 'caused by the disruption of' the patient's 'vital energy'. The patient hears this but does not accept these claims. He does, however, humour the acupuncturist by pretending to go along with it, and finds that the treatments do help.

Does the acupuncturist introduce false beliefs? No. Does she sustain the patient's false beliefs at all? No. So, despite the pretence here, the acupuncturist is still providing 'non-deceptive care'. The verdict would change if, when pretending, the acupuncturist intended to introduce or sustain false beliefs in the patient's mind.

^{iv}This case is closely based on another case given by Hardman.¹

But providers who engage in pretence (or those who promote hope) need not possess such intentions. Understanding 'non-deceptive care' as the actual inverse of 'deceptive care', therefore, provides conceptual space for the inclusion of cases that Hardman claimed were (mistakenly) excluded.

QUESTIONS OF DECEPTION, QUESTIONS OF NORMATIVITY

Lastly, asking whether care is deceptive differs from asking whether it is appropriate. Hardman's discussion fails to account for this distinction adequately. To illustrate, consider his final case:

3. A physician agrees to change a patient's prescription despite there being a 'lack of clinical evidence' that doing so will help. Without saying anything false, the physician pretends that the new drug 'is more straightforwardly effective' than is supported by evidence. This is done because the physician judges that the patient needs 'a confident and empathic medication switch'.¹

Is this deceptive care? According to Hardman, it is unclear. He notes that 'many clinicians...would argue that in this situation deception is not only about truth and falsity'.¹ Furthermore, by pretending, the physician 'demonstrates care, tact, and empathic understanding' of the patient's situation.¹

Here, Hardman—and clinicians for whom he speaks—conflate questions of deception with questions of normativity; whether deception occurs is separate from whether physicians act appropriately.^v Fortunately, the distinction between deception and normativity has been widely discussed. Miller, for example, suggests that when deception is justifiable, it is because other virtues or principles, 'such as benevolence or non-malevolence, take greater priority...and end up justifying' dishonesty, 'all things considered'.² And, importantly, 'even morally justifiable' dishonesty 'is a failure of honesty'.² Hence, caring, tactful, and empathic care is still deceptive care when physicians intend that their patients form (or sustain) some false belief(s). Does case 3 involve deceptive care? The question remains easy to answer (in principle). If the physician

^vThat is, unless one assumes that physicians should never deceive their patients. But since that claim is contentious (and central within the debate with which Hardman is engaging), it should not be assumed here.

intends that their patient forms (or retains) false beliefs, then yes. If not, then no.

Importantly, Hardman reasons that in case 3 (or cases involving pretence), deception does not obviously occur. By embracing the claim that intention is a necessary part of deception, we can argue exactly that; pretence does not entail any intent that one's patient forms (or sustains) some false belief(s). This provides Hardman with a principled and simplified way of vindicating the view that what the physician does in case 3 is not deceptive. 'Simplified' because it primarily requires an understanding of deception (the concept), not the full 'interactional' and/or 'wider social, context' in which the clinical encounter occurs.¹ And 'principled' because the result follows straightforwardly from a clear (and plausible) account of deception.

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