Pretending to care

Doug Hardman
Bournemouth University
dihardman@bournemouth.ac.uk

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Abstract

On one hand it is commonly accepted that clinicians should not deceive their patients, yet on the other there are many instances in which deception could be in a patient's best interest. In this paper, I propose that this conflict is in part driven by a narrow conception of deception as contingent on belief. I argue that we cannot equate non-deceptive care solely with introducing or sustaining a patient's true belief about their condition or treatment, because there are many instances of clinical care which are non-doxastic and non-deceptive. Inasmuch as this is true, better understanding of non-doxastic attitudes, such as hope and pretence, could improve our understanding of deception in clinical practice.

Determining deception

On one hand it is commonly accepted that clinicians should not deceive their patients, yet on the other there are many instances in which deception could be in a patient's best interest. Ethicists have long been interested in this problem, insofar as it reveals a conflict between two purportedly fundamental principles: respect for autonomy and beneficence.[1–3] Furthermore, empirical research suggests that patients find some kinds of deception acceptable in some circumstances, undermining the idea that avoiding deception can act as a universal precept for clinical practice.[4–9] As with many issues in medical ethics, deception seems more complicated than it first appears. Given the muddle we have gotten into by treating deception in terms of principles, I propose instead to investigate it by careful consideration of everyday clinical situations in which it could arise.[10–13] To get us started, let's consider a situation, which at first look seems deceptive, whereby a clinician prescribes a treatment they know to be effective for treating other conditions.

(1) Mrs Atkins sits in the chair next to her doctor's desk, telling him how bad she has been feeling and how she would really like to get better before she goes on holiday next week. "If you could just give me some antibiotics to nip this in the bud, that would really help." Despite being unsure whether Mrs Atkins has a viral or a bacterial infection, Dr Crace gives her a prescription for amoxicillin and sends her on her way with some kind words.

Although this is a seemingly simple situation, it has several interpretations. (i) Mrs Atkins does not really understand the distinction between a bacterial and a viral infection but knows that she has had antibiotics before and they made her better. Dr Crace's afternoon

surgery is running late and, although he does not think that antibiotics will help, he just wants to get to the next patient so he can go home at a reasonable hour. (ii) Mrs Atkins thinks she has a bacterial infection and wants some antibiotics to make her feel better. Dr Crace is fairly sure that it is a viral infection but he is not certain. As Mrs Atkins is quite old and not in great health, he thinks it is worth the risk prescribing antibiotics, even considering his broader aim to reduce such prescriptions due to the risk of antibiotic resistance. (iii) Mrs Atkins is not sure if she has bacterial infection but wants some antibiotics as she hopes they will help her feel better. Dr Crace prescribes the antibiotics but tells Mrs Atkins that it is likely she does not have a bacterial infection and that he does not think she will need them. He tells her that he is prescribing them so she has them in reserve on holiday, just in case. He instructs her only to take them if her condition deteriorates when she is away.

There are more interpretations we could make of this situation, but these three give us enough to be getting on with. In interpretation (i) it seems sensible to class the situation as deceptive, insofar as Dr Crace makes no effort to communicate his actual diagnosis and discuss the possible treatment options with Mrs Atkins. Instead, he prescribes antibiotics to placate Mrs Atkins and in so doing sustains an erroneous belief that they will effectively treat her infection. In interpretations (ii) and (iii), however, the deception is not so clear cut.

In interpretation (ii), the issue seems more about uncertainty than deception; one could argue that Dr Crace is just being prudent. However, even though there is a possibility that Mrs Atkins has a bacterial infection, on the balance of probabilities Dr Crace still thinks not. Thus, one could also argue that, even in this case, he is being deceptive, or at best overly paternalistic. Furthermore, prescribing amoxicillin is not without risk, insofar as side-effects such as stomach cramps, vomiting and diarrhoea could significantly impact Mrs Atkins. On reflection, it seems difficult to make a useful judgement on the nature of deception in this interpretation without better understanding a range of contextual factors, including Mrs Atkins' medical history, her character, and her relationship with Dr Crace.

In interpretation (iii), Dr Crace tries to communicate to Mrs Atkins that he does not think she will need the antibiotics but gives her a prescription to hold in reserve, thus making her feel heeded and perhaps less anxious about going abroad. Knowing Mrs Atkins as he does, Dr Crace thinks it likely that, once she starts to feel better, she won't take the antibiotics so there is no harm in prescribing them. Again, in this interpretation it does not seem right to describe Dr Crace's practice as deceptive, even if one could perhaps identify some equivocation. After all, it is not the case that Mrs Atkins misbelieves that she has a bacterial infection and that Dr Crace is sustaining this false belief. Rather, Dr Crace is using the process of prescribing to support and reassure Mrs Atkins. Because in this interpretation we have a little more information on the relationship between Mrs Atkins and Dr Crace, we are in a better position to judge whether the case could be described as deceptive or not. Nevertheless, it is still clear that in this interpretation a judgement of deception remains underdetermined.

In considering various interpretations of a seemingly simple situation, we have uncovered some interesting aspects of deception; in particular, the common notion that deception involves introducing or sustaining a patient's false or erroneous belief about their

condition or treatment. Nevertheless, we have again got into a bit of a muddle. Beyond very clear cases, it seems difficult to say whether a clinician is introducing or sustaining a patient's false or erroneous belief. It turns out that, even in a simple situation, we need to understand the interactional context in order to determine whether deception is involved or even what can be classed as deception in the first place. With this in mind, let's change tack and consider a situation which, at first look, seems non-deceptive. Perhaps looking at deception from that angle will help us better understand it in clinical practice.

Deceptively non-deceptive

(2) Frank has been suffering with low back pain for some years. After trying many unsuccessful treatments, one of his friends suggests he try acupuncture. Frank is sceptical but as nothing else has worked, he gives it a go. In his first consultation, Frank lies face down in the treatment bed as Mia, the acupuncturist, swabs the area around his lower back with an alcohol wipe. "The pain in your back is caused by the disruption of qi – by which I mean vital energy – in your body," explains Mia, "qi flows along pathways or meridians in your body. I will try to remove blockages in the flow of qi by inserting very thin needles into your skin at specific points in your body that connect with these meridians." Frank doesn't really know what to make of all this but, nevertheless, by the end of the 30-minute session he is feeling relaxed. After a few sessions, he starts to feel less pain in his back. He still doesn't really believe all this qi stuff, but he likes the environment Mia creates in the consultations and thinks that buying into her explanations helps him relax and enjoy the acupuncture more.

In this example, Frank is enjoying and getting clinical benefit from his acupuncture sessions. Despite not believing the claims made about qi and its flow along meridians, Frank seems to enjoy the atmosphere Mia creates in her consultations, of which such traditional explanations are a part. Moreover, as it seems Mia herself genuinely believes what she is telling Frank, and the treatment works, one could argue that, in any case, Frank's beliefs do not really matter. If Mia is not intentionally deceiving Frank and Frank does not think that Mia has any intention to deceive, then surely by any sensible criteria, this situation does not involve deception. However, as with example (1), although at first look it seems simple to determine whether deception has occurred, we can easily muddy the waters with some additional contextual detail. For example, Mia's belief in the veracity of the traditional explanation of acupuncture could be grounded in research that, by the standards of modern medicine, is not credible. Thus, although she believes what she is saying, one could argue that she is unintentionally attempting to deceive Frank, insofar as her belief is mistaken and as a clinician, she has a responsibility to stay informed about the evidence for and against her practice. Furthermore, given the limitations regarding the availability of evidence for complementary treatments such as acupuncture, one could argue that there are questions about the necessary burden of proof required to assuage any risk of deception in such treatments. On this view, deception is not merely an interpersonal question involving Frank and Mia, but a social question involving the system of determining the safety and efficacy of treatments.

As demonstrated above, determining whether acupuncture is deceptive is not quite as simple as first thought, because some explanations or statements given to patients cannot be

easily classed as deceptive or not. Determining deception entails a difficult judgment of the veracity of the statements explaining how acupuncture works and their application to the particular context. It seems that, in focussing on acupuncture, we have again alighted upon the issue that arose in example (1). In many clinical situations, it is difficult to determine whether a treatment involves an untenable amount of deception without understanding the interactional, and on some views even the wider social, context. This, I argue, is because in many situations it is difficult to determine the veracity of clinician disclosures and whether they contribute to sustaining or invoking patients' erroneous or false beliefs. It seems we have come to a bit of a dead end. We have concluded that in many cases even a determination of deception is highly contextual. As such, it is difficult to know where to go next. To try to get back on track, I propose starting from an alternative interpretation of the interactional context in the clinic, in which the roles of true, erroneous, and false beliefs are downgraded. This might open up a different interpretation and delineation of deception, which could offer a new and potentially useful perspective.

Pretending to care

In exploring the interactional context that determines a judgement of deception, I have focussed on the importance of belief, insofar as deceptive care involves introducing or sustaining a patient's false or erroneous belief about their condition or treatment, and non-deceptive care involves the inverse. However, belief is merely one attitude among many. Recent research has begun to foreground the importance of non-doxastic attitudes in clinical practice, In particular, there is an increasing amount of research which suggests that hope is an important attitude in clinical practice.[14] For example, some research suggests that cancer patients regularly reinterpret unfavourable prognostics in order to maintain hope [15], and other research suggests that hope is a dynamic process entangled with experiences of chronic pain [16].

However, although hope can be classed as a non-doxastic attitude and thus set against belief-based accounts, standard accounts of hope in philosophy and psychology do not make this clear. For example, the standard philosophical account of hope takes it to include two aspects: a desire for an outcome and at least some degree of belief in that outcome's possibility [17,18]. The standard psychological account mirrors this double aspect, insofar as hope is conceived as a motivational construct involving both a desire to strive for a goal and belief about how to achieve it.[19,20] Therefore, standard accounts of hope in philosophy and psychology question the attitude's non-doxastic status: i.e., its separation from belief. In response to such belief-based accounts of hope, however, some argue that the standard account of hope is deficient because it does not explain the many instances in which we are hopeful about possibilities we do not really think will happen.[21] In response, they propose a more substantial account of hope, which entails acting *as if* something is, or has a good chance of, obtaining.[21] In other words, hope entails, in a non-trivial sense, *pretending* that something will occur. Thus, although hope is often invoked as an important non-doxastic attitude, it is perhaps more useful in such cases to highlight an alternative attitude: pretence.

Related to research on hope, there is some evidence that pretence is important in healthcare and that pretending influences clinical outcomes in important ways.[22,23] For

example, anthropological studies have identified various functions of clinicians and patients pretending – or acting *as if* – in various clinical contexts, including utilising uncertainty throughout an illness trajectory [24,25], and enacting efficacious treatment contexts in primary care [26] Returning to example (2), within a framework that affords importance to the attitude of pretence as well as belief, inconclusive debate on Mia's or Frank's belief in the proffered explanation of acupuncture becomes unnecessary. Neither Frank nor Mia need believe in the explanation, they just need to act as if it is true for the duration of the consultation, which is enough to enact an efficacious treatment context and promote therapeutic effects.[26]

From an ethical perspective, if non-doxastic attitudes are an important and accepted aspect of clinical practice – as recent studies including views of patients and clinicians in various contexts suggests [26–28] – then it undermines the traditional deception/non-deception dichotomy grounded solely in belief. Although deceptive practice would still be defined as introducing or sustaining a patient's false or erroneous belief about their condition or treatment, non-deceptive practice would not merely be the inverse. There would, in addition, be many instances of clinical care which would be non-doxastic yet non-deceptive, insofar as the clinical encounter in such situations would be grounded in attitudes unrelated to belief. On this interpretation, non-deceptive medical practice is unshackled from belief, widening the scope of what can sensibly be considered non-deceptive in modern medicine. With this in mind, let's consider a final example.

(3) Steven enters the consultation room and is welcomed by his GP, Dr Akinfenwa. "My therapist said my depression score was 22" says Steven, "and that it might be a good idea to change medication." Dr Akinfenwa asks Steven a few questions before suggesting a way forward. "I know you've been feeling very sleepy recently Steven, so why don't we change it up and get you onto Sertraline, which shouldn't be so much of a problem." She explains that it will take about six weeks to get settled on the new medication and finishes the consultation by scheduling a follow-up appointment in a month, noting that Steven can come in at any point before that if he is having problems.

In this example, we encounter a more mainstream medical situation than in example (2). Given the lack of clinical evidence for one or another selective serotonin reuptake inhibitor (SSRI) – or even agreement that the underlying theory is correct [29] – Dr Akinfenwa judges that what Steven needs at this stage is a confident and empathic medication switch. Yet, if one foregrounds the importance of belief in determining deception, one could argue that Dr Akinfenwa is being deceptive, insofar as she minimises debate about the effectiveness of Sertraline. Many clinicians, however, would argue that in this situation deception is not only about truth and falsity. Rather, in acting as if Sertraline is more straightforwardly effective than evidence suggests, Dr Akinfenwa demonstrates care, tact, and empathic understanding of Steven's situation and clinical need. In other words, by pretending that Sertraline is more straightforwardly effective she enacts a more effective interactional context through a process that, it seems reasonable to surmise, Steven would on reflection likely not oppose. As in example (2), here we see evidence for the clinical utility of pretence within a non-deceptive framework.

Conclusion

In exploring various clinical situations, I have uncovered different aspects of deception in clinical practice. First, the common idea that deception involves introducing or sustaining a patient's false or erroneous belief about their condition or treatment. Second, although it is commonly held that non-deceptive clinical practice involves the inverse of this, I propose that such a characterisation only encompasses some non-deceptive clinical care. In addition, I argue that there are many instances of clinical care which are non-doxastic and non-deceptive. As such, I argue that we cannot equate non-deceptive care solely with introducing or sustaining a patient's true belief about their condition or treatment; non-deceptive care can also involve non-doxastic attitudes such as hope and pretence. Better understanding of these attitudes could improve our understanding of deception in clinical practice.

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