Unintentional deception still deceives

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Abstract

In my recent article, *Pretending to care*, I argue that a better understanding of non-doxastic attitudes could improve our understanding of deception in clinical practice. In an insightful and well-argued response, Colgrove highlights three problems with my account. For the sake of brevity, in this reply I focus on the first: that my definition of deception is implausible because it does not involve intention. Although I concede that my initial broad definition needs modification, I argue that it should not be modified by involving intention but by involving responsibility.

In my recent article, *Pretending to care*, I argue that a better understanding of non-doxastic attitudes could improve our understanding of deception in clinical practice.[1] In an insightful and well-argued response, Colgrove highlights three problems with my account: (i) that my definition of deception is implausible because it does not involve intention; (ii) that my definition of non-deceptive care is too narrow; and (iii) that I conflate questions of deception with questions of normativity.[2] I concede that Colgrove's definition of non-deceptive care is better; although, as Colgrove himself notes, his definition still accommodates instances of clinical care which are non-doxastic and non-deceptive. I also concede that it is important not to conflate questions of deception with questions of normativity. For the sake of brevity, however, in this reply I focus on the first problem.

In noting correctly that my broad definition of deception in medicine – introducing or sustaining a patient's false or erroneous belief – does not require intention, Colgrove argues that this view has 'absurd implications'. To illustrate his point, he describes a (somewhat unusual) clinical situation in which a patient with type 2 diabetes believes that if their physician says they need to monitor their blood sugar then that proves that all physicians are pawns for Big Pharma. Colgrove then goes on to show that, in this situation, even if the physician merely makes the reasonable statement that the patient needs to monitor their blood sugar, by my definition they are deceiving the patient because they have sustained a false belief. Colgrove argues that this sets the bar for providing non-deceptive care impossibly high. He further argues that the problem dissolves if deception in medicine is instead defined as *intentionally* introducing or sustaining a patient's false or erroneous belief.

There is some debate in philosophy, and medical ethics in particular, on whether deception involves intention.[3–6] With this in mind, let's consider another example. Alex, a fit 19 year old college student, collapses on a run. He manages to self-recover but is rushed to hospital and undergoes a battery of tests, including an electrocardiogram (EKG), exercise stress test, cardiac ultrasound, and cardiac catheterization test. Alex's initial EKG shows serious arrhythmia, including a prolonged QT interval, but further tests show nothing unusual. Alex's father, a medical scientist, suggests that they should compare the initial EKG results with a baseline EKG that Alex had recently undergone in the Air Force Officer selection process, but his physicians do not think this relevant. Alex is discharged with no further instructions. One of his physician tells Alex not to worry and that he is in better shape than any of the staff at the hospital. During a follow-up consultation, Alex is given the all-clear and returns to training. Two weeks later he collapses during a run and dies. The cause of death is identified as sudden cardiac death due to long QT syndrome, an inherited heart problem that affects how one's heart beats.

In this tragic example – adapted from a patient story published by the Society to Improve Diagnosis in Medicine [7] – it seems quite sensible to state that, in sustaining Alex's false belief that he is fit and healthy, the physician has deceived Alex, albeit unintentionally. Colgrove, in response, might argue that this is a not a case of deception but one of mere

'accidental misleading', which Colgrove proposes is different to deceiving.[1] However, when considered in light of a physician's obligation to their patients, it seems wrong to class this as an accident. As well as accruing significant rights, such as prescribing powers, physicians also accrue significant obligations. In this case, the physician is obligated to have a good understanding of conditions such as long OT syndrome and to use the available tools at hand in their diagnosis. In failing to meet these obligations, they have not been involved in an accident but have made a mistake. And, as Austin famously showed, although it matters if someone did something intentionally or not, it also matters whether the consequences of one's actions happened by accident or by mistake.

The important factor in determining deception in this situation is not whether it was intended or not, but where responsibility lies. Given the physician's obligations, one could credibly conclude that they were responsible for deceiving (or misleading) Alex and thus the situation can be classed as deceptive (especially if one conceives of misleading as a mode of deception). On Colgrove's definition, however, this situation would be classed as non-deceptive merely because the physician did not intend to deceive. It seems that, although my broad definition of deception sets the bar for non-deceptive care too high, Colgrove's definition sets it too low.

To resolve this issue, I propose a modification of my initial definition which does not involve intention but instead involves responsibility: deception in medicine involves *being responsible for* introducing or sustaining a patient's false or erroneous belief.[2] On these terms, Alex's case involves deception because the physician is responsible for sustaining Alex's false belief that he is fit and healthy by (in this case unintentionally) bringing about misleading evidence to sustain that belief. Whereas Colgrove's diabetes case is classed as non-deceptive because the physician cannot plausibly be held responsible for sustaining the patient's false belief, insofar as they merely made a reasonable statement. This definition thus avoids both the high bar set by my initial broad definition and the low bar set by Colgrove's modification.

[1] As an aside, it a debatable point as to whether misleading and deceiving are usefully conceived as different. One could equally argue that misleading (accidental or otherwise) is a *mode of* deception (such as, for example, lying).

[2] A narrower version of this definition is: deception in medicine involves introducing or sustaining a patient's false or erroneous belief *by bringing about evidence*.

References

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