

Conspiracy theories and clinical decision-making

Nathan Stout 

Department of Clinical Ethics, University Hospitals, Cleveland Medical Center, Cleveland, OH, USA

Correspondence

Nathan Stout, Department of Clinical Ethics, University Hospitals, Cleveland Medical Center, 11100 Euclid Ave, Cleveland, 44106, OH.

Email: nathan.stout@uhhospitals.org

Abstract

When a patient's treatment decisions are the product of delusion, this is often taken as a paradigmatic case of undermined decisional capacity. That is to say, when a patient refuses treatment on the basis of beliefs that in no way reflect reality, clinicians and ethicists tend to agree that their refusal is not valid. During the COVID-19 pandemic, however, we have witnessed many patients refuse potentially life-saving interventions not based on delusion but on conspiracy beliefs. Importantly, many of the beliefs espoused by conspiracy theorists resemble delusions in a number of relevant ways. For instance, conspiracy beliefs often posit states of affairs that could not possibly exist in the world, they are recalcitrant in the face of disconfirming evidence, and they tend to put the believer in a state of paranoia. Given these similarities, how should we think about conspiracy theorists' capacity for making clinical decisions? In this paper, I attempt to answer this question by first offering an account of just what makes some set of beliefs count as a conspiracy theory. Second, I attempt to disambiguate conspiracy beliefs from delusions by exploring important conceptual and psychological features of both. Finally, I apply standard criteria for assessing a patient's decision-making capacity to instances of conspiracy beliefs and argue that, although the picture is muddy, there may be cases in which conspiracy beliefs undermine capacity. I end by exploring the implications that this might have for surrogate decision-making and addressing potential objections.

KEYWORDS

clinical ethics, conspiracy theories, decision-making capacity

1 | INTRODUCTION

The presence of conspiracy theories is by no means a new phenomenon in American society. In each generation, commentators are prone to declare theirs to be the age of the conspiracy theory. There is little evidence to support such declarations,¹ and the truth is that conspiracy theories have likely always had some purchase in every society of any complexity. In fact, we might go even further and argue, along with Joseph Uscinski, that *everyone* believes in at

least one conspiracy theory. Given the ubiquity of conspiracy thinking, it is surprising that philosophers have had relatively little to say about it. Moreover, given the number of conspiracy theories that involve claims directly related to issues of health and medicine, it is also surprising that bioethicists have had almost nothing to say about them. With this paper, I hope to bring bioethicists into the conversation on conspiracy theories by showing that conspiracy beliefs butt up against one of the central topics in clinical ethics, namely, decision-making capacity.

I suspect that bioethicists have been uninterested in conspiracy theories largely because the effects of such theories in medicine have been underappreciated. Conspiracy theorists are

¹Uscinski, J. (2020). *Conspiracy theories: A primer*. Rowman & Littlefield.

often seen as making up a rather small and mostly insular segment of the broader population, and their theories are taken to be largely inconsequential to medicine writ large. However, this view strikes me as short-sighted. As Uscinski writes, "Conspiracy theories are not fringe ideas, tucked neatly away in the dark corners of society. They are politically, economically, and socially relevant to all of us ... When people believe conspiracy theories, they may act on them."² And this is especially true in medicine, where the effects of conspiracy theories can be particularly devastating. For example, conspiracy theories in developed countries regarding genetically modified foods have led to anti-GMO importation policies that have had strong negative impacts on developing countries. AIDS-related conspiracy theories endorsed by some government officials in Africa have led to perhaps hundreds of thousands of needless deaths. Some conspiracy theorists believe that water fluoridation is a government conspiracy to ensure that the citizenry remains dumb and docile in order that those in power might institute totalitarian (or communist, depending on who you ask) rule. Proponents of this theory have convinced some municipalities to forego fluoridation, with a measurable negative impact on dental health.³ In addition to these, we could add the widely held conspiracy theory that climate change does not exist but is rather a hoax perpetrated by scientists who are in the pocket of some sinister shadow organization and faking data. Such beliefs have led to decreased likelihood of taking personal action to reduce climate change and the dire health consequences that come along with that.⁴ Finally, conspiracy theories have played an outsize role in responses to the COVID-19 pandemic.

COVID conspiracy theories, predictably given our political climate, have been plentiful. The following are just a few of the conspiracy theories that have gained currency during the pandemic:

- (1) COVID-19 is caused by 5G cellular networks, and this is being hidden from the public by powerful telecom companies.
- (2) The COVID-19 pandemic was caused (or at least foreseen) by Bill Gates as part of his plan to vaccinate the world's population through his foundation.
- (3) SARS-CoV2 is a biological weapon created by China in the Wuhan Institute of Virology, which is actually a covert arm of China's biological warfare program.
- (4) SARS-Cov2 is a biological weapon created by the United States and imported to Wuhan in an effort to undermine China's global position by blaming the Chinese for the pandemic.
- (5) COVID-19 does not exist.

- (6) COVID-19 was spread intentionally by the "deep state" in an effort to undermine Donald Trump's chances of winning re-election.⁵

As in the cases above, these conspiracy theories are associated with worse health outcomes. Unsurprisingly, a recent study has shown that individuals who espouse COVID-19 conspiracy beliefs are less likely to be tested for COVID-19, more likely to have a positive test when they are tested, and more likely to have violated COVID-19 safety protocols.⁶ In some cases, these conspiracy beliefs have led to violence, as, for example, when several 5G towers were set on fire in the UK by adherents of this particular theory. Clearly, then, health-related conspiracy theories stand to have widespread detrimental, and sometimes deadly, consequences.

I will attempt to show in this paper that, in addition to the broad public health consequences just described, conspiracy theories raise ethical questions in the one-to-one clinical context as well. Rather than issue any sweeping guidelines regarding the ethics of dealing with conspiracy theories and those who believe them, I am going to keep my aim narrow. I want to examine how these types of conspiracy beliefs manifest themselves in clinical decision-making and whether their presence should cast doubt on the validity of particular decisions made by patients. To illustrate this, I will begin with a pair of cases involving refusal of treatment:

Case #1: Mr. Adams is brought to the ER by his neighbor. He is febrile and has a large wound on his arm that is showing clear signs of infection with pain and swelling around the affected area. The emergency physician proceeds to clean and disinfect Mr. Adams' wound and to start a course of antibiotics. Mr. Adams refuses the medication. He claims that he is the target of government assassins who believe that he has access to classified state secrets. He says he knows this because he's seen his mail carrier, who is actually an undercover CIA agent, spying on him and taking photographs when he thinks Mr. Adams isn't looking. He refuses to take any antibiotics because he believes that they are actually poisons that the assassins will use to murder him. He openly wonders whether the doctors are in on the plot.

Case #2: Ms. Greene is brought to the ER by her daughter. She has recently tested positive for COVID-19 and is experiencing acute respiratory distress. She is sent to the COVID unit of the hospital, and the team prepares to begin treatment with Remdesivir in the hopes of preventing further progression of her illness. Ms. Greene refuses. She says that COVID-19 is a

²Uscinski, J. (2019). Down the rabbit hole we go. In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 1–32). Oxford University Press. p. 1.

³Ibid: 11.

⁴Uscinski, J., Karen, D., & Stephan, L. (2017). Climate change conspiracy theories. In H. von Storch (Ed.), *Oxford research encyclopedia of climate science* (pp. 1–40). Oxford University Press. Retrieved November 9, 2021.

⁵Lynas, M. (2020). COVID: Top 10 current conspiracy theories. Alliance for Science. Retrieved November 9, 2021, from <https://allianceforscience.cornell.edu/blog/2020/04/covid-top-10-current-conspiracy-theories/>

⁶van Prooijen, J.-W., Etienne, T. W., Kutiyiski, Y., & Krouwel, A. P. M. (2021). Conspiracy beliefs prospectively predict health behavior and well-being during a pandemic. *Psychological Medicine*, 1–8. <https://doi.org/10.1017/S0033291721004438>

hoax. It was fabricated by a worldwide cabal of Satan-worshipping, liberal elites who operate a global child sex-trafficking ring. These monsters, she says, murder young children and drink their blood in order to extract a substance known as adrenochrome, which gives them eternal life. Any so-called "treatment" for COVID-19 is just part of their plot to kill supporters of Donald Trump, whose destiny it is to expose them and bring them to justice.

In Case #1, Mr. Adams' declarations about government assassins are a paradigmatic case of persecutory delusion. In Case #2, Ms. Greene's claims about Satan-worshipping cannibals are a succinct statement of the basic tenets of the QAnon conspiracy theory. Though the case that I have presented is hypothetical, it is not unrealistic. According to a recent poll, "15 percent of Americans say they think that the levers of power are controlled by a cabal of Satan-worshipping pedophiles, a core belief of QAnon supporters."⁷ At least one member of the US House of Representatives has openly endorsed these claims as well.

It is uncontroversial in clinical ethics that a patient who is refusing treatment on the basis of delusional beliefs lacks the capacity to make a valid refusal. However, the same has never been said, to my knowledge, about decisions made on the basis of conspiracy beliefs. Ms. Greene's beliefs in case #2 are not, on their face, any less preposterous than Mr. Adams' delusional beliefs in case #1. Does this mean that we should treat them in the same way for the purposes of clinical decision-making? If so, does this entail that conspiracy theorists are incapacitated to make certain treatment decisions?

I will return to these questions below but answering them requires first laying some conceptual groundwork. I will begin to do so in Section 2 by attempting to offer a working definition of a conspiracy theory. In Section 3, I will aim to identify what, if anything, sets conspiracy beliefs apart from delusions. In Section 4, I will apply standard criteria for assessing a patient's decision-making capacity to instances of conspiracy beliefs and argue that, although the picture is muddy, conspiracy beliefs can, in fact, undermine capacity. I will end in Section 5 by exploring the implications that this might have for surrogate decision-making and addressing potential objections.

2 | WHAT IS A CONSPIRACY THEORY?

To begin, it is important to note that there is no single, universally accepted definition of the term "conspiracy theory." Scholars who study conspiracy theories have defined them in a variety of ways, and the concept itself is surprisingly resistant to analysis. Nevertheless, there are several characteristics that are often included in definitions of conspiracy theories that will give us a foothold on some of the important aspects of the concept. Jan Willem van Prooijen argues

that there are five necessary conditions that must be satisfied in order for some set of beliefs to count as a conspiracy theory. Those five conditions are as follows:

- (1) Patterns—Any conspiracy theory explains events by establishing nonrandom connections between actions, objects, and people.
- (2) Agency—A conspiracy theory assumes that a suspect event was caused on purpose by intelligent actors: There was a sophisticated and detailed plan that was intentionally developed and carried out.
- (3) Coalitions—A conspiracy theory always involves a coalition or group of multiple actors.
- (4) Hostility—A conspiracy theory tends to assume the suspected coalition to pursue goals that are evil, selfish, or otherwise not in the public interest.
- (5) Continued secrecy—Conspiracy theories are about coalitions that operate in secret.⁸

Similarly, Uscinski defines "conspiracy" as involving "a small group of powerful individuals acting in secret for their own benefit and against the common good," and "conspiracy theory" as "an explanation of past, present, or future events or circumstances that cites, as the primary cause, a conspiracy. Like conspiracies, conspiracy theories involve the intentions and actions of powerful people..."⁹ While there are subtle differences between these two definitions, they delineate the conceptual contours of conspiracy theories in ways that are sufficiently similar for my purposes here. However, neither of these, it seems to me, capture the concept perfectly.

One difficulty with both of these conceptions has to do with the condition of secrecy that both authors include. While most conspiracy theories posit that the conspiracy in question is perpetrated in secret, it is unclear just how far the secrecy must go. Take, as an example, the infamous Tuskegee Syphilis experiments.¹⁰ This tragic event bears the hallmarks of a medical conspiracy perpetrated against its victims. However, while the true nature of what was done was kept secret from those who were harmed, the experiment itself was not particularly secretive. Those running the study published multiple papers about it in prominent medical journals. Moreover, documents detailing the specifics of the study passed through multiple Public Health Service administrations over the course of several decades while the study was ongoing. So, while the victims of Tuskegee were certainly in the dark as to what was truly happening, the conspiracy itself was not a secret.¹¹

⁸van Prooijen, J.-W. (2018). *The psychology of conspiracy theories* (pp. 5–6). Routledge.

⁹Uscinski, op. cit. note 1, pp. 22–23.

¹⁰For a helpful summary and analysis of the events surrounding Tuskegee, see Jones, J. H. (2011). The Tuskegee Syphilis experiment. In E. J. Emanuel, C. Grady, R. A. Crouch, R. K. Lie, F. G. Miller, & D. Wendler (Eds.), *The Oxford textbook of clinical research ethics* (pp. 86–96). Oxford University Press.

¹¹What should we make of this? On the one hand, we might say that the study was indeed secretive insofar as it was not widely known outside of the medical community, but this would imply that any doctor who read published reports about the study was, as a result, a co-conspirator, which seems a step too far. On the other hand, we might simply say that any degree of secrecy is sufficient for something's counting as a conspiracy, but this too is

⁷Rusonello, G. (2021, May 27). QAnon now as popular in U.S. as some major religions, poll suggests. *New York Times*. Retrieved November 9, 2021, from <https://www.nytimes.com/2021/05/27/us/politics/qanon-republicans-trump.html>

Nevertheless, the types of conspiracy theories that concern us here uniformly meet the stronger secrecy condition that van Prooijen and Uscinski use, so we can set this conceptual wrinkle aside for now.

Other authors argue that central to the concept of conspiracy theories is the fact that such theories are, by definition, false. Karl Popper seems to hold this view in his work *The Open Society and Its Enemies*.¹² As M. R. X. Dentith¹³ points out, several more recent commentators take this view as well. As they note, Swami et al. “define conspiracy theories ‘as a subset of false beliefs ... in which the ultimate cause of an event is believed to be due to a plot by multiple actors working together with a clear goal in mind, often unlawfully and in secret’.”¹⁴ Many others have rejected the by-definition-false claim with respect to conspiracy theories,¹⁵ and rightfully so, to my mind.

As a result of this disagreement, much of the philosophical literature on conspiracy theories has focused on trying to delineate the conditions under which it would be rational to believe in a conspiracy theory. I do not wish to engage in that debate here. However, I do think it is important to note that from that debate arose the view that we ought to have some way of distinguishing plausible conspiracy theories from implausible ones. After all, history is littered with examples of conspiracy theories that, upon investigation, have turned out to be true. The reason that this is important is because when we hear talk of conspiracy theories in popular culture, the focal point seems clearly to be on those theories that strike us as generally outlandish. As Jesse Walker¹⁶ has pointed out, by tracing the common usage of the term “conspiracy theory,” we can see a definite evolution toward this understanding.

So, for the remainder of this paper, when I discuss conspiracy theories, I'll hew closely to the definition provided by van Prooijen above. *Conspiracy theories are explanations of events that posit definite, nonrandom, causal patterns perpetrated in secret by a coalition of agents with nefarious goals.* Moreover, when I talk of conspiracy theories, I will primarily be focused on what Brian Keeley¹⁷ refers to as “unwarranted” conspiracy theories. Keeley argues that conspiracies become unwarranted when they reach a degree of complexity such that it becomes increasingly unlikely that the conspiracy could remain a secret, given the number of conspirators who would have to be a part of it. Others have given different plausibility conditions. Uscinski, for example, argues that conspiracy theories ought not to be believed unless they can be confirmed by epistemic authorities. However, I will remain agnostic as to the standards for plausibility. As

Preston Bost writes, “We may not be able to tell you what a conspiracy theory is, but we know one when we see it.”¹⁸ Likewise, we can know an unwarranted conspiracy theory when we see one. It is plausible, perhaps, to believe that Lee Harvey Oswald did not act alone. It is not plausible to believe, along with David Icke, that the planet is secretly run by an ancient race of lizard people.

3 | CONSPIRACY THEORIES AND DELUSIONS

Let us return now to the cases of Mr. Adams and Ms. Greene that I presented above. As I stated previously, if we are to come to different conclusions regarding their decision-making capacity, then we need to have some way of assigning different statuses to their respective beliefs.

Is there any difference in kind between the refusal of care in Case #1 and the refusal in Case #2? If so, what is the difference?

To begin, we might just answer the first question in the negative and hold that conspiracy beliefs are but a type of delusion. However, this response does not seem promising. As van Prooijen¹⁹ argues, tempting though it may be to write off conspiracy beliefs as pathological, it is a stretch to believe that pathology can tell the whole story, given just how widespread conspiracy beliefs are. After all, if 15% of American adults believe in the basic claims of QAnon, and such beliefs were pathological, then QAnon would instantly be one of the most common mental disorders in the country—more common than ADHD, PTSD, and Generalized Anxiety Disorder combined.²⁰ Thus, pathologizing conspiracy beliefs seems to misconstrue them in some important sense.

To get clearer on the differences between the two cases, it will be helpful to look to the DSM-5 for a general account of delusion, and specifically persecutory delusion, as this bears the greatest resemblance to conspiracy beliefs. According to the DSM, “Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence.” Moreover, “Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences.”²¹ So far, this definition does not do much to differentiate delusions from conspiracy beliefs. Conspiracy beliefs tend to be fixed and not amenable to change as well. Indeed, unfalsifiability is often seen as a hallmark of conspiracy beliefs. Keeley makes note of this when he points out the fact that when faced with potentially falsifying evidence, the conspiracy theorist always has recourse to the claim

potentially problematic as it seems we will have trouble drawing a line between conspiracies and any sort of group deception at all.

¹²Popper, K. (1966). *The open society and its enemies, Volume 2: The high tide of prophecy: Hegel, Marx, and the Aftermath* (pp. 94–99). Routledge.

¹³Dentith, M. R. X. (2019). Conspiracy theories and philosophy: Bringing the epistemology of a freighted term into the social sciences. In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 94–108). Oxford University Press.

¹⁴Ibid: 95.

¹⁵See, for example, Pidgen, C. (1995). Popper revisited, or, what is wrong with conspiracy theories? *Philosophy of the Social Sciences*, 25(1), 3–34.

¹⁶Walker, J. (2019). What we mean when we say ‘conspiracy theory.’ In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 53–61). Oxford University Press.

¹⁷Keeley, B. (1999). Of conspiracy theories. *Journal of Philosophy*, 96(3), 109–126.

¹⁸Bost, P. R. (2019). The truth is around here somewhere: integrating the research on conspiracy beliefs. In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 269–282). Oxford University Press. p. 271.

¹⁹van Prooijen, op. cit. note 8.

²⁰Anxiety & Depression Association of America. (2022). *Understanding anxiety and depression: Facts and statistics*. Retrieved November 9, 2021, from <https://adaa.org/understanding-anxiety/facts-statistics>

²¹American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

that the evidence is phony—it is just the kind of thing that the conspirators would *want* us to believe.

Returning to the DSM-5, in order for an individual to be diagnosed with Delusional Disorder, the following diagnostic criteria must be fulfilled:

- (1) The presence of one (or more) delusions with a duration of 1 month or longer.
- (2) Criterion A for schizophrenia has never been met.
- (3) Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
- (4) If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
- (5) The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

It goes on to specify specific subtypes of delusion. Among these is the persecutory variety, about which it states: “This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.” Again, the conspiracy theorist seems to fit these criteria quite neatly. The characterization of persecutory delusion even makes explicit reference to conspiracy beliefs.

Given the above definitions of delusion and characterization of delusional disorder, it seems to me that there are three features that differentiate persecutory delusions from conspiracy beliefs. First, according to the DSM definition of persecutory delusions, these delusions are individualized in a way that conspiracy beliefs are not. Wood and Douglas make this point as well, saying “Persecutory delusions differ from what are usually called conspiracy theories in that delusions usually propose a conspiracy against the deluded person themselves ... However, conspiracy theories ... tend to be much broader in scope.”²² So, the delusional thinker believes that someone is out to get him or her in particular, but the conspiracy theorist believes that the conspirators are out to get some much larger social group of which he or she is a member. Second, delusions show a high degree of individual variability.²³ That is, they tend not to be believed by more than one person (with exceptions, perhaps, of the rare *folie a deux* phenomenon). Delusions are believed by an individual, whereas conspiracy theories are believed en masse. Finally, delusions and conspiracy beliefs seem

to differ on the basis of etiology. Although it is not known what causes delusional disorder, it is presumed that there must be some genetic, biological, or environmental basis for it.²⁴ No similar explanation is posited with respect to conspiracy beliefs. Rather, in the case of conspiracy theories, individuals arrive at their conspiratorial beliefs either by their own poor manipulation of evidence or by being convinced of their truth by others. This difference in etiology, it seems to me, is a helpful way of moving beyond the temptation to pathologize all conspiracy beliefs.

Nevertheless, even if conspiracy beliefs are not pathological in and of themselves, it may still be possible to identify particular psychological characteristics that predispose individuals to believe in conspiracy theories, and many psychologists have attempted to do just that. In the 1960s, Richard Hofstadter famously conceptualized conspiracy theorizing as “the manifestation of a ‘paranoid style.’”²⁵ Subsequently, others identified a plethora of additional cognitive and personality traits that correlate with a propensity toward conspiracy beliefs. Wood and Douglas, like Hofstadter, also note that nonclinical paranoia correlates highly with conspiracy beliefs and that individuals with higher degrees of schizotypy are generally more prone to believe in conspiracy theories. Van Prooijen²⁶ posits that natural cognitive tendencies toward pattern perception and agency detection incline individuals to believe in conspiracy theories. He also argues that social factors such as the desire to connect to a shared identity and responding to perceived outgroup threats have this same effect as well. Uscinski²⁷ summarizes a sizable portion of the psychological literature on conspiracy beliefs and highlights several additional correlations that are claimed in the literature on the psychology of conspiracy theories. These include cognitive traits such as an intolerance for uncertainty, overactive “cheater detectors,” intentionality bias, motivated reasoning, and diminished capacity for critical thinking, as well as personality traits such as anxious attachment style, avoidant attachment style, narcissism, magical thinking, Manichean thinking, hallucination proneness, and paranormal or supernatural ideation. Clearly, then, a wide range of cognitive and psychosocial processes may incline individuals toward conspiratorial thinking that are not overtly pathological and that do not necessarily involve delusions on the part of the individual who subscribes to a given conspiracy theory.²⁸

²⁴Cleveland Clinic. (2018). *Delusional disorder*. Retrieved November 9, 2021, from <https://my.clevelandclinic.org/health/diseases/9599-delusional-disorder>

²⁵Butter, M., & Knight, P. (2019). The history of conspiracy theory research: A review and commentary. In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 33–46). Oxford University Press. p. 33.

²⁶van Prooijen, op. cit. note 8.

²⁷Uscinski, op. cit. note 1.

²⁸Given the array of psychological features associated with conspiracy beliefs, it may be prudent to understand them as related to delusion in an important way. Daniel Freeman (2006) argues that nonclinical paranoid thinking is very common in the general public and that this kind of thinking is generally on a continuum with more severe, clinical delusional thinking. Perhaps, conspiratorial thinking is but a point on that continuum.

²²Wood, M. J., & Douglas, K. M. (2019). Conspiracy theory psychology: Individual differences, worldviews, and states of mind. In J. Uscinski (Ed.), *Conspiracy theories & the people who believe them* (pp. 245–256). Oxford University Press. p. 247.

²³Freeman, D. (2007). Suspicious minds: The psychology of persecutory delusions. *Clinical Psychology Review*, 27, 425–457.

4 | CONSPIRACY BELIEFS AND DECISION-MAKING CAPACITY

So, we now have some means of differentiating the kinds of beliefs that are at issue in our two cases. In Case #1, Mr. Adams' belief is an instance of persecutory delusion insofar as it rests on a conspiracy against him as an individual and, let us stipulate, has some biological, genetic, or environmental basis. Ms. Greene's beliefs, on the other hand, are not delusional insofar as the conspiracy that she endorses is generalized, shared by roughly 25 million other Americans, and her beliefs were *arrived at* through some cognitive process, however poor it may have been. This, I think, is a helpful way of carving up the conceptual landscape. However, it does not yet tell us anything about the status of the refusals that the patient makes in each of our two cases. In order to say anything about the validity of either patient's refusal, we need to evaluate the decision-making capacity of each. Despite the distinction between conspiracy beliefs and delusions that I have just elucidated, it remains the case that our two hypothetical refusals are remarkably similar in many respects. Both are divorced from reality in a significant way, both evince high degrees of paranoid thinking, etc. If this is true, and if we take the view that delusions are, at least in some cases, sufficient to undermine decision-making capacity, then we still need to ask whether the two cases are sufficiently similar so as to make the same determination in each. I turn to this problem now.

While there is no universally agreed upon standard for determining decision-making capacity²⁹ (Boyle, 2004), there are several approaches that are widely used in clinical practice. Here, I am going to make use of the so-called MacArthur model of decision-making capacity developed and validated by Appelbaum & Grisso.³⁰ According to this model, in order for a patient to have the capacity to make a given decision, that patient must be able to communicate a choice, understand relevant information, appreciate the situation and its consequences, and rationally manipulate information. Importantly, decision-making capacity is always understood as being specific to a particular decision. That is, the question is not "can this patient make decisions for themselves?" Rather, the question is, "is this patient capable of making this particular decision?" As a result, it would be incorrect to suppose that the presence of a delusion undermines decision-making capacity in general. Indeed, studies have shown that delusional patients commonly retain decision-making capacity.³¹ However, this is not the case when the decision in question is directly connected to the patient's delusion. To see why, let us return to our case of Mr. Adams.

In my hypothetical example, Mr. Adams is clearly able to communicate a choice. Presumably, that choice would remain stable, at least in the near term. He may well also be able to understand the relevant information. That is, he may understand that his arm is infected, he may understand that the infection could get worse, and he may understand that especially bad infections pose serious health risks. However, in the case of delusions, when patients fail to fulfill the criteria for decision-making capacity, it is generally due to a lack of appreciation or ability to rationally manipulate information. In Mr. Adams' case, he may recognize that antibiotics are good for curing infections, but he fails to appreciate that this is true in his own case. Rather, in his case, antibiotics are dangerous poisons that government agents are using to try to murder him. Insofar as his delusion is irrational, he may fail to fulfill the fourth capacity criterion as well. His irrational beliefs are interfering with his ability to make rational inferences about his medical care. Thus, in Mr. Adams' case, his refusal of the intervention is not valid due to his lack of decision-making capacity.

The question for our purposes, then, is whether we can make the same argument in the case of conspiracy beliefs. Surely, as in the case of delusion, the mere existence of a conspiracy belief cannot undermine capacity. If it did and Uscinski is correct that all of us believe at least one conspiracy theory, then none of us could make decisions. Even in the case of unwarranted conspiracy theories, it would be false to say that the presence of these beliefs undermines capacity in general. Surely a person could, say, believe that the United Nations is hiding the fact that the Earth is flat and consent to an MRI, say. If we are to make a case that conspiracy beliefs undermine decision-making capacity, then it must be the case that those beliefs are in some way implicated in the decision at hand.

So, let us return to our QAnon believer, Ms. Greene. Like Mr. Adams, she is clearly able to communicate a choice. She may also be able to understand the relevant information—the doctors believe that she has a disease called COVID-19, they think she may become seriously ill if it is not treated, and they believe that they have a drug that could effectively treat it. Like Mr. Adams, however, it seems to me that she is unable to appreciate the situation. After all, she believes that the disease the doctors say she has does not exist, so how could she appreciate that it is currently threatening her life? Moreover, it seems unlikely that she could engage in any sort of rational means–end reasoning regarding the decision to refuse treatment with Remdesivir. Thus, she seems to be in exactly the same situation as Mr. Adams.

Recall that earlier, I noted three ways in which conspiracy beliefs differ from delusions: they are individualized, singular, and differ in etiology. Do any of these differences matter to us when evaluating an individual's capacity to make a particular clinical decision? I cannot see any reason why they should. If Ms. Greene cannot appreciate her situation or the consequences of her decision, and if her conspiracy beliefs are preventing her from rationally manipulating information, then why should we care whether the beliefs are about her own situation or something larger than herself? Why should we care how she came to hold these beliefs or whether others agree with her? Insofar as the MacArthur criteria (along with many other criteria)

²⁹Boyle, R. J. (2004). Determining patients' capacity to share in decision making. In J. C. Fletcher, P. A. Lombardo, & E. M. Spencer (Eds.), *Introduction to clinical ethics* (3rd ed., pp. 117–138). University Publishing Group.

³⁰Appelbaum, P. S., & Grisso, T. (1995). The MacArthur Treatment Competence Study (I): Mental illness and competence to consent to treatment. *Law and Human Behavior*, 19, 105–126.

³¹Spencer, B. W. J., Gergel, T., Hotopf, M., & Owen, G. (2018). Unwell in hospital but not incapable: Dissociation of decision-making capacity for treatment and research in inpatients with schizophrenia and related psychoses. A cross sectional study. *British Journal of Psychiatry*, 213(2), 484–489.

assess the patient's functional ability to make decisions, they will be indifferent to these external features of conspiracy beliefs. Therefore, I think that we are forced to conclude that in cases in which a patient endorses an unwarranted conspiracy theory, and their clinical decisions are based in some substantial part on that conspiracy theory, we should deem the patient incapable of making the decision in question. Admittedly, such cases will be rare, but given the prevalence of unwarranted conspiracy beliefs, clinicians should be prepared to encounter them.

5 | SURROGATE DECISIONS AND SLIPPERY SLOPES

To this point, I have argued for a conception of conspiracy theories as explanations of events that posit definite, nonrandom, causal patterns perpetrated in secret by a coalition of agents with nefarious goals and that meet a threshold of implausibility. I have differentiated conspiracy theories from delusions by noting that conspiracy beliefs tend to posit broad groups as the victims of the conspiracy, that they are often believed by large numbers of people rather than lone individuals, and that they have a different etiology than delusions—they are *arrived at* either by way of poor reasoning or through convincing by third parties. Finally, I have argued that although conspiracy theories are distinct from delusions, they can undermine a patient's decision-making capacity in some cases. Having said this, I would now like to explore two important difficulties that might arise if we accept that conspiracy beliefs can undermine decision-making capacity.

First, some conspiracy theories may pose serious problems for surrogate decision-makers. Once a patient has been deemed incapable of making a particular decision, we of course do not proceed to compelling treatment or allowing clinicians to decide on their behalf. Rather, the next step is to recruit a surrogate decision-maker to step in and decide for the patient. The duty of the surrogate in such cases, then, is to make a substituted judgment. That is, they are tasked with making the decision that the patient would have made if the patient were capacitated. The difficulties that surrogates have with making successful substituted judgments are well documented, but setting those worries aside, the standard view in practice is that a surrogate who has some insight into the patient's values and preferences can draw on that information in order to reconstruct the decision that the patient would have made if they were able. In many cases, this is unproblematic. Take our case of Mr. Adams as an example. Here, an appropriate surrogate could presumably set aside his delusional belief that he is the target of government assassins and decide to proceed with antibiotic treatment on the basis of Mr. Adams' expressed values and preferences outside of his deluded state. In the case of conspiracy theories, however, this process does not seem as straightforward.

Let us return to the case of Ms. Greene. In her case, the conspiracy theory to which she subscribes differs in its scope and complexity from the delusions experienced by Mr. Adams. The QAnon conspiracy theory is massive and incorporates a wide range of other conspiracy theories

within it. QAnon believers see themselves as key members of a coalition that is fighting evil in the world. The basic premise of the theory, as I noted earlier, is that Donald Trump was appointed as president by the military so that he could put an end to a global cabal of Satan-worshipping pedophiles. According to QAnon supporters, virtually every elite, liberal politician, celebrity, or other public figure is involved in a massive child sex-trafficking operation and takes part in cannibalistic rituals that give them everlasting life. QAnon supporters believe that an event, which they call "The Storm," will take place in the future in which Donald Trump will lead the military in rounding up these evil-doers and there will be mass, public executions of everyone involved in the plot. As evidence of this, QAnon supporters appeal to cryptic messages that are posted on the online forum 8chan (formerly 4chan) by an anonymous poster known only as "Q," who claims to have access to top secret military intelligence. As the conspiracy theory has grown, it has incorporated other classic conspiracy theories as well. QAnon supporters claim that the Satan-worshipping pedophiles are implicated in the coverup of the JFK assassination, hiding the truth about the flat earth, framing Timothy McVeigh for the Oklahoma City bombing, and, of course, the hoax that is the COVID-19 pandemic. Many also believe that the poster known as Q is actually John F. Kennedy Jr., who is not dead but merely faked his death. So firm is their belief that hundreds of QAnon supporters recently gathered in Dallas at the site of the JFK assassination, believing that JFK Jr. would return and announce himself as Donald Trump's running mate in the 2024 presidential election.³² Imagine their disappointment when the confirmed-dead man was a no-show. I go into some detail about the specifics of the QAnon theory because understanding its breadth is important for the problem at hand. The theory is so wide-ranging that it looks less like a circumscribed theory of some particular event and more like an entire worldview. It seems, for many adherents, to also constitute a key part of their practical identity.

If this is true, and the theory has grown to the point of being, for some, a comprehensive worldview, then it is entirely unclear how a surrogate decision-maker could set aside belief in it in order to make a substituted judgment. If adherence to the theory is what undermines decision-making capacity, but the theory itself has come to occupy such a central place in the life of the patient, what is the surrogate to do? In a sense, asking what the patient would decide if they were capable in this case is to ask what the patient would decide if they were someone else and not the patient. This is a difficult problem, and it raises serious questions about how to handle surrogate decision-making in light of conspiracy theories when they reach the point of constituting the patient's evaluative perspective.

One potential solution to this problem would be to defer to the patient's evaluative perspective prior to their conspiratorial turn. Many family members of QAnon supporters have described their loved ones as having become "radicalized" by conspiracy theories in a rather short period of time, and so it may be possible to reconstruct the decision that the patient would have made prior to this radical

³²Kornfield, M. (2021). Why hundreds of QAnon supporters showed up in Dallas, expecting JFK Jr.'s return. *The Washington Post*. Retrieved January 12, 2022, from <https://www.washingtonpost.com/nation/2021/11/02/qanon-jfk-jr-dallas/>

transformation.³³ Another solution would be to hold that substituted judgments are not possible in some cases for such conspiracy theorists and to attempt to decide, instead, on the basis of a best interest standard. Perhaps one could identify the values that underly their pervasive misunderstandings and irrationalities and attempt to articulate a decision that would be in the patient's interests, given those values. Accomplishing this would, no doubt, be very difficult. The broader point is that some pervasive, all-encompassing conspiracy beliefs will require clinicians and ethicists to rethink how surrogate decision-making will need to be done for patients who adhere to them.

The second problem with the view that conspiracy theories may undermine decision-making capacity is that one may worry that this sets us on a slippery slope of sorts. If we take this attitude toward conspiracy theories, one might say, what is to stop us from taking the same attitude toward other contentious beliefs? Should we also consider those who endorse particular theological or religious beliefs to be incapacitated? To use a standard textbook example, it is well established in clinical ethics that the decision of a Jehovah's Witness to refuse a blood transfusion ought to be respected and their capacity not questioned. Surely, though, some secular people would consider the views of a Jehovah's Witness to not be different, in kind, from those of a conspiracy theorist. So, what explains the differential judgments in the two cases?

A full discussion of the rationality of religious belief is beyond the scope of this paper. However, we should be able to say at least something in favor of respecting religious beliefs in a way that we ought not respect unwarranted conspiracy theories. One way of doing this, I think, is to point to the fact that unwarranted conspiracy theories are typically *demonstrably* false, whereas many religious beliefs are not. Reasonable people disagree about the existence of God, and arguably, we lack a definitive demonstration of God's existence or nonexistence. The same cannot be said about, say, the flat Earth conspiracy theory. We *know* the Earth is a globe because we know how to look at stars and do math.

I confess that this answer is not fully satisfying. When it comes to some more fringe or unorthodox religious doctrines, more may need to be said to satisfactorily distinguish them from the types of beliefs held by conspiracy theorists. I fully agree that patients ought to be allowed to make decisions on the basis of their religious beliefs, and yet, I am also sympathetic to the claim that certain religious beliefs seem just as irrational as some of the outlandish conspiratorial beliefs that I have mentioned in this paper. If, as I have argued, we should at times consider conspiracy theorists incapacitated to make decisions on the basis of their conspiracy beliefs, then this undoubtedly raises uncomfortable questions about the capacity of patients who make

decisions on the basis of certain religious beliefs as well. In my opinion, more consideration needs to be given to this problem going forward.

6 | CONCLUSION

Conspiracy theories have always had currency in American society. Written off as mostly inconsequential, they have not received nearly the scholarly attention that they deserve. Conspiracy theories are resistant to clear definition, they resemble pathological delusions in many important ways, and they may, as I have argued here, undermine a patient's ability to make medical decisions. As a result, they require rigorous philosophical analysis. The role that conspiracy beliefs have played in the public response to the COVID-19 pandemic has brought into sharp relief the need for bioethicists to devote serious attention to addressing conspiracy theories and their impact on healthcare practices and institutions. In this paper, my aim has been at once modest and ambitious. It is modest insofar as what I have attempted to show is simply that conspiracy beliefs may have considerable impacts at the individual level of clinical decision-making that clinicians and clinical ethicists need to be proactive about considering. It is ambitious in that I hope for it to serve as part of an opening salvo in what needs to be an extensive bioethics debate over the proper response to the growing influence of conspiracy theories in healthcare.

CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

ORCID

Nathan Stout  <http://orcid.org/0000-0002-3887-3427>

AUTHOR BIOGRAPHY

Nathan Stout, PhD, is a clinical ethicist at University Hospitals, Cleveland Medical Center, and clinical assistant professor in the Department of Bioethics at Case Western Reserve University School of Medicine. He earned his PhD in philosophy from Tulane University in 2016, and he completed a postdoctoral fellowship in clinical bioethics in the Program for Medical Ethics and Human Values in the Tulane University School of Medicine and the New Orleans VA Medical Center in 2019. He specializes in issues regarding moral agency and responsibility, autonomy, and decision-making capacity, and he has published on a wide range of topics in clinical ethics and moral philosophy.

³³This is, in some ways, similar to a familiar debate in bioethics regarding how/whether to adhere to advance directives for dementia patients. In some cases, the person with dementia no longer agrees with the decisions that are outlined in the advance directive that was completed prior to the onset of their dementia, and there is considerable debate as to whether the patient's current or prior evaluative perspective should govern their present healthcare (see, e.g., Jaworska, A. (1999). Respecting the margins of agency: Alzheimer's patients and the capacity to value. *Philosophy and Public Affairs*, 28(2), 105–138).

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