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RESPONSE

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Conspiracy theories, clinical decision-making, and need for bioethics debate: A response to Stout

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Abstract

Although people who endorse conspiracy theories related to medicine often have negative attitudes toward particular health care measures and may even shun the healthcare system in general, conspiracy theories have received rather meager attention in bioethics literature. Consequently, and given that conspiracy theorizing appears rather prevalent, it has been maintained that there is significant need for bioethics debate over how to deal with conspiracy theories. While the proposals have typically focused on the effects that unwarranted conspiracy theories have in the public health context, Nathan Stout's recent argument concentrates on the impacts that such theories have at the individual level of clinical decision-making. In this article, I maintain that duly acknowledging the impacts of conspiracy theories that raise Stout's concern does not require bioethics debate over the proper response to the influence of conspiracy theories in healthcare. Having evaluated two possible objections, I conclude by briefly clarifying the purported import of the response to Stout.

KEYWORDS
capacity assessment, clinical decision-making, conspiracy beliefs, conspiracy theories, decision-making capacity, surrogate decision-making

1 | INTRODUCTION

The theories that the COVID-19 outbreak was planned, that large pharmaceutical companies conceal effective treatments for cancer, and that AIDS deaths are caused by retroviral medication are examples of conspiracy theories related to medicine. People who endorse such theories often have negative attitudes towards particular health care measures and may even shun the healthcare system in general.[1] As conspiracy theories have nevertheless received rather meager attention in bioethics literature, and given that conspiracy theorizing appears to be rather prevalent,[2] it has

[1]See also, for example, Douglas, K.M., & Sutton, R.M. (2018). Why conspiracy theories matter: A social psychological analysis. *European Review of Social Psychology, 29*(1), 256–298; Douglas, K. M., Sutton, R. M., & Cichocka, A. (2017). The psychology of conspiracy theories. Current Directions in Psychological Science, 26(6), 538–542; Jolley, D., & Douglas, K. (2014). The effects of anti-vaccine conspiracy theories on vaccination intentions. *PLoS One, 9*(2), e89177; Leonard, M-J., & Philippe, F. L. (2021). Conspiracy theories: A public health concern and how to address it. *Frontiers in Psychology, 12*, 682931; Oliver, E., & Wood, M. J. (2014). Medical conspiracy theories and health behaviors in the United States. *JAMA Internal Medicine, 174*(5), 817–818; Prooijen van, J-W., Etienne, T. W., Kutiyski, Y., & Krouwel, A. P. M. (2021). Conspiracy beliefs prospectively predict health behavior and well-being during a pandemic. *Psychological Medicine, 13*, 1–8; Romer, D., & Jamieson, K. H. (2020). Conspiracy theories as barriers to controlling the spread of COVID-19 in the U.S. *Social Science & Medicine, 263*, 113356.

[2]See, for example, Andrade, G. (2020). Medical conspiracy theories: Cognitive science and implications for ethics. *Medicine, Health Care and Philosophy, 23*(3), 505–518; Oliver & Wood, op. cit. note 1.

been maintained that there is significant need for bioethics debate over how to deal with conspiracy theories. Such proposals have typically concentrated on the effects that unwarranted conspiracy theories have in the public health context.[3] Yet, Nathan Stout's recent argument focuses on the impacts that unwarranted conspiracy theories have at the individual level of clinical decision-making.[4]

Stout's central starting point is that "[i]t 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."[5] Based on comparison of treatment refusals grounded on persecutory delusions with treatment refusals grounded on unwarranted conspiracy theories, Stout argues that "conspiracy beliefs [beliefs in conspiracy theories] may have considerable impacts at the individual level of clinical decision-making that clinicians and clinical ethicists need to be proactive about considering."[6] Therefore, Stout concludes that we need "extensive bioethics debate over the proper response to the growing influence of conspiracy theories in healthcare."[7] In this article, I respond to Stout's worry about the impacts of unwarranted conspiracy theories at the individual level of clinical decision-making. After recapitulating his argument, I maintain that duly acknowledging the impacts of conspiracy theories that raise Stout's concern does not require bioethics debate over the proper response to the influence of conspiracy theories in healthcare. Having evaluated two possible objections, I conclude by briefly clarifying the purported import of the response to Stout.

2 | STOUT'S ARGUMENT FOR EXTENSIVE BIOETHICS DEBATE OVER THE PROPER RESPONSE TO THE INFLUENCE OF CONSPIRACY THEORIES IN HEALTHCARE

Acknowledging that there is no single, universally shared understanding of the term "conspiracy theory," Stout adopts the working definition of conspiracy theories as "explanations of events that posit definite, nonrandom, causal patterns perpetrated in secret by a coalition of agents with nefarious goals."[8] As proposed, Stout's argument for extensive bioethics debate over the proper response to the influence of conspiracy theories in healthcare—henceforth just Stout's argument, for short—focuses on unwarranted conspiracy theories. Stout remains agnostic as to how, precisely, unwarranted conspiracy theories can be distinguished from warranted ones, but believes that "we can know an unwarranted conspiracy theory when we see one."[9] Stout's argument also relies on the conception of (persecutory) delusions and of the definition of Delusional Disorder presented in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) and on the MacArthur model of decision-making.

According to the DSM-5, delusions "are fixed beliefs that are not amenable to change in light of conflicting evidence."[10] 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."[11] In the case of persecutory delusions, "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."[12] A person's receiving a diagnosis of Delusional Disorder presupposes, to put it briefly, that he has delusions with a duration of 1 month or longer, but with no accompanying prominent hallucinations, thought disorder, mood disorder, or significant flattening of affect.[13] And, according to the MacArthur model of decision-making, a person has the capacity to make a decision when she has adequate abilities to communicate a choice, understand relevant information, appreciate the nature of the situation and its likely consequences, and rationally manipulate information.[14]

Stout maintains that unwarranted conspiracy theories differ from persecutory delusions in that persecutory delusions usually propose a conspiracy against the deluded person only, tend not to be believed by others, and are presumed to have a genetic, biological, or environmental basis, whereas conspiracy theories tend to have a larger scope, are believed en masse, and are rather arrived at by people's own poor manipulation of evidence or by being convinced by others.[15] With these starting points, Stout turns to assessing a pair

[3]See, for example, Andrade, op. cit. note 2; Leonard & Philippe, op. cit. note 1; Romer & Jamieson, op. cit. note 1. Public health is primarily focused on the health of a population, directed toward preventing and reducing harm to physical, psychological, and social well-being (and not just providing treatment) at a population level, and strives after goals, the attainment of which presupposes collective action, see also, for example, Dawson, A. (2011). Resetting the parameters: Public health as the foundation for public health ethics. In Dawson, A. (Ed.) *Public health ethics: Key concepts and issues in policy and practice* (pp. 1–19). Cambridge University Press.

[4]Stout, N. (2023). Conspiracy theories and clinical decision-making. *Bioethics*, *37*(5), 470–477; see also, for example, Andrade, op. cit. note 2, p. 506; Oliver & Wood, op. cit. note 1. During the last few decades, conspiracy theories have received increasing attention in social scientific research, see, for example, Douglas, K. M., Uscinski, J. E., Sutton, R. M., Cichocka, A., Nefes, T., Ang, C. S., & Deravi, F. (2019). Understanding conspiracy theories. *Advances in Political Psychology*, *40*(Suppl. 1), 3–35 and the references in note 1 above. Yet, so far, philosophical work on conspiracy theories has mostly focused on epistemological questions, see, for example, Baurmann, M., & Cohnitz, D. (2021). Trust no one? The (social) epistemological consequences of belief in conspiracy theories. In S. Bernecker, A. K. Flowerree, & T. Grundmann (Eds.), *The epistemology of fake news* (pp. 334–357). Oxford University Press; Boudry, M. (2022). Why we should be suspicious of conspiracy theories: A novel demarcation problem. *Episteme*, *20*, 1–21. https://doi.org/10.1017/epi.2022.34; Galbraith, D. (2022). Pigden revisited, or in defence of Popper's critique of the conspiracy theory of society. *Philosophy of the Social Sciences*, *52*(4), 235-257.

[5]Stout, op. cit. note 4, p. 472.

[6]Ibid: 477.

[7]Ibid.

[8]Ibid: 473. See also, for example, van Prooijen, J.-W. (2018). *The psychology of conspiracy theories* (pp. 5–6). Routledge, and note 21 below; c.f. for example, Cibik, M. & Hardoš, P. (2022). Conspiracy theories and reasonable pluralism. *European Journal of Political Theory*, *21*(3), 445–465.

[9]Ibid.

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

[11]Ibid.

[12]Ibid.

[13]The rough characterization of Delusional Disorder suffices for the present purposes. For a more detailed account of the condition, see, for example, Stout, op. cit. note 4, p. 474.

[14]Applebaum, 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.

[15]Stout, op. cit. note 4, p. 474. Stout also says that unwarranted conspiracy beliefs are too widespread to be written off as pathological. Ibid: 473.

of cases that can be recapitulated as follows. Mr. Adams is brought to the emergency room because he has a large wound. As the wound shows clear signs of serious infection, the health care provider treating Mr. Adams recommends a course of antibiotics. Mr. Adams deludedly thinks that the medication is poison used by government assassins who believe that he has access to classified state secrets. Consequently, Mr. Adams refuses the medication, and openly wonders whether his health care provider is in on the government plot. Ms. Greene has been tested positive for COVID-19 and is brought to the emergency room because she experiences acute respiratory distress. She is sent to the COVID unit of the hospital and the medical team there prepares to treat her with Remdesivir. Ms. Greene thinks that COVID-19 is a hoax and that the treatment proposed to her is a part of a plot by a cabal of Satan-worshiping, child-molesting liberal elites who aim to kill supporters of Donald Trump, whose destiny it is to bring the cabalists to justice. Consequently, Ms. Greene refuses the treatment.

Stout proposes that both Mr. Adams and Ms. Greene are unable to adequately appreciate their situation and that their irrational beliefs likely threaten their ability to make rational inferences about their medical care. He also says that he is unable to see any reason why the three differences between persecutory delusions and conspiracy theories explicated above would make Ms. Greene's case importantly different from the case of Mr. Adams in terms of the patients' capacity to validly refuse the treatments proposed to them. Consequently, Stout infers that, as Mr. Adams plausibly lacks capacity validly to refuse the treatment proposed to him, Ms. Greene plausibly lacks capacity validly to refuse the treatment proposed to her.[16] Besides arguing that patients such as Mr. Adams and Ms. Greene are relevantly similar to each other in terms of their ability to validly refuse the treatments proposed to them, Stout also draws attention to surrogate decision-making in cases of incapacitated patients whose unwarranted conspiracy beliefs constitute a key part of the patients' practical identities.

In Mr. Adams' case, a surrogate decision-maker can, according to Stout, set aside the patient's delusional beliefs about government assassins and proceed with antibiotic treatment on the basis of the patient's expressed values and preferences outside of his deluded state. But when an unwarranted conspiracy theory has grown to the point of being a patient's comprehensive worldview, Stout continues, "it is entirely unclear how a surrogate decision-maker could set aside belief in it in order to make a substituted judgment."[17] Accordingly, Stout proposes that unwarranted conspiracy beliefs that are central to patients' practical identities motivate the rethinking of current surrogate decision-making practices.[18] Given that unwarranted conspiracy theories have the above-described kinds of significance at the individual level of clinical decision-making, Stout concludes that there is need for "extensive bioethics debate over the proper response to the growing influence of conspiracy theories in healthcare."[19]

[16]Ibid: 475–476.
[17]Stout, op. cit. note 4, p. 476.
[18]Ibid: 476–477.
[19]Ibid: 477.

3 | A PROBLEM FOR STOUT'S ARGUMENT

To begin with, while Stout proposes that the influence of conspiracy theories is growing in healthcare,[20] studies on the prevalence of conspiracy theorizing suggest otherwise. Joseph Uscinski and his colleagues, for instance, describe the results of their recent study on belief in conspiracy theories as follows:

> Across four studies––including four distinct operationalizations of conspiracism [belief in conspiracy theories], temporal comparisons spanning between 7 months and 55 years, and tens of thousands of observations from seven nations––we find only scant evidence that conspiracism, however operationalized, has increased. … In fact, we identified more decreases than increases, and the decreases were larger in magnitude than the increases. That only a quarter of the conspiracy theories that we examined found more support over time––none of which involve the COVID-19 pandemic or QAnon––contradicts common wisdom.[21]

It would also seem that distinguishing unwarranted conspiracy theories from warranted ones can sometimes be more difficult than Stout suggests. Moreover, although health care providers may be less inclined to endorse unwarranted conspiracy theories related to medicine than are other people, such theories may nevertheless sometimes detrimentally affect the thinking of health care providers too.[22] And instead of the substituted judgment standard on which Stout focuses, a surrogate decision-maker could be legally obligated to employ the best interests standard, according to which a surrogate is to decide based on what, in general, would be good for the patient.[23] The best interests standard typically does not aim to capture the patient's specific values and preferences, but is rather interpreted in terms of what a "reasonable" person would want

[20]Stout, op. cit. note 4, p. 477.
[21]Uscinski, J., Enders, A., Klofstad, C., Seelig, M., Drochon, H., Premaratne, K., & Murthi, M. (2022). Have beliefs in conspiracy theories increased over time? *PLoS One*, *17*(7), e0270429, 15–16. The authors' definition of a conspiracy theory accords with that used by Stout and the authors understand a conspiracy theory belief as one's acceptance that a specific conspiracy theory is (likely) true (Ibid: 3). Admittedly, even if belief in conspiracy theories were decreasing, advocacy of conspiracy theories can, as Uscinski and his colleagues also suggest, nevertheless remain on significant levels.
[22]Whether refusing a treatment and consenting to it presuppose different degrees of decision-making capacity has been debated in bioethics literature, see, for example, Pickering, N. J., Newton-Howes, G., & Walker, S. (2022). Risk-related standards of competence are a nonsense. *Journal of Medical Ethics*, *48*(11), 893–898; Lawlor, R. (2016). Cake or death? Ending confusions about asymmetries between consent and refusal. *Journal of Medical Ethics*, *42*(11), 748–754; Wilks, I. (1999). Asymmetrical competence. *Bioethics*, *13*(2), 154–159. Instead of going into that debate, I now follow Stout and focus on treatment refusal only. Besides treatment refusal, the following considerations pertain to refusal to participate in medical research procedures as well.
[23]Yet, in clinical ethics, it is rather commonly accepted that the best interests standard is to be used only when the patient's preferences and values are not known and cannot reasonably be inferred, see, for example, The American Medical Association. (2017). Code of Medical Ethics. Opinion 2.1.2. https://code-medical-ethics.ama-assn.org/ethics-opinions/decisions-adult-patients-who-lack-capacity; Brock, D. W. (2007). Patient competence and surrogate decision-making. In R. Rhodes, L. P. Francis, & A. Silvers (Eds.), *The Blackwell guide to medical ethics* (pp. 128–141). Blackwell Publishing; Jaworska, A. (2017). Advance directives and substitute decision-making. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Summer 2017 Edition). https://plato.stanford.edu/archives/sum2017/entries/advance-directives/.

under the circumstances. Accordingly, an incapacitated patient whose practical identity is based on their unwarranted conspiracy beliefs would not seem to constitute a special problem for surrogate decision-making that relies on the best interests standard. Yet, let us now put such complications to Stout's argument aside and turn to what would appear to be a more significant problem for it.

Upon hearing his reasons for refusing the treatment that they propose to him, health care providers treating a patient such as Mr. Adams rather clearly have reason to doubt the patient's decision-making capacity. Yet, assuming that they follow commonly accepted clinical ethics practices,[24] the health care providers would nevertheless need to ascertain whether the patient after all has adequate abilities validly to refuse the treatment. Consequently, the health care providers would, or at least plausibly should, discuss the patient's reasons for refusing the treatment with him and see how he reacts to the counterevidence for the reasons, for example. Given that the capacity assessment is based on the MacArthur model of decision-making, the health care providers would try to find out whether the patient actually is unable to understand relevant information, appreciate the nature of his situation and its likely consequences, and rationally manipulate the information. Hence, to determine whether the treatment refusal of their patient is valid, the question on which the health care providers would, or at least plausibly should, focus is whether the patient has the pertinent decision-making abilities.[25]

In these respects, the cases of Ms. Greene and Mr. Adams are plausibly relevantly similar to each other.[26] Consequent to learning about her grounds for refusing the treatment that they propose to her, health care providers treating a patient such as Ms. Greene rather evidently have reason to question the patient's decision-making capacity. However, given that they adhere to commonly endorsed clinical ethics practices, the health care providers would still need to determine whether the patient nevertheless has adequate abilities validly to refuse the treatment.[27] Consequently, the health care providers would, or at least plausibly should, confer the patient's grounds for refusing the treatment with her and see how she responds to the counterevidence for the grounds, for example. Given that the capacity assessment is based on the MacArthur model of decision-making, the health care providers would try to discover whether the patient really is unable to comprehend pertinent information, appreciate the nature of her situation and its likely consequences, and rationally manipulate the information. Hence, to decide whether their patient's treatment refusal is valid, the question on which the health care providers would, or at least plausibly should, concentrate is whether the patient has the pertinent decision-making abilities.

Given that Mr. Adams holds on to his reasons for refusing the treatment proposed to him, his health care providers could, and assumedly relatively easily, infer that their patient lacks the decision-making abilities that his validly refusing the treatment presupposes. Consequently, the health care providers would assumedly conclude that they should resort to surrogate decision-making. Here too, the cases of patients such as Ms. Greene and Mr. Adams are plausibly relevantly similar to each other. Given that Ms. Greene does not give up her grounds for refusing the treatment proposed to her, her health care providers could, and assumedly comparatively effortlessly, conclude that she does not have the decision-making abilities that her validly refusing the treatment presupposes. Consequently, the health care providers would probably infer that they should utilize surrogate decision-making. Hence, as Stout maintains, in terms of the patients' capacity to validly refuse the treatments proposed to them, the cases of Mr. Adams and Ms. Greene are plausibly relevantly similar to each other.

Yet, contrary to what Stout suggests, the similarity of the cases does not entail that there is a need for extensive bioethics debate on how properly to respond to the influence that unwarranted conspiracy theories have at the individual level of clinical decision-making. For, as proposed by the above consideration of the cases of Mr. Adams and Ms. Greene, the central question for health care providers assessing the validity of a patient's treatment refusal is whether the patient has the decision-making abilities that validly refusing the treatment presupposes. From the viewpoint of that question, the precise grounds of the lack of decision-making abilities of a patient who turns out to be incapacitated are immaterial. Hence, that the lack of decision-making abilities of a patient such as Ms. Greene has the particular basis it has—that the lack relates to her endorsing an unwarranted conspiracy theory—plausibly does not make a difference here and health care providers proceeding in the way Ms. Greene's health care providers were described to proceed above act quite as they should.

Finally, even if Mr. Adams' delusional beliefs were not central to his practical identity, the delusional beliefs of a dementia patient or a person with schizophrenia, for example, can sometimes grow to the point of constituting that patient's comprehensive world-view.[28] Consider, then, the case of Ms. Jordan, a patient whose persecutory delusions have grown to the point of constituting her

[24]See, for example, Beauchamp, T. L. & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed., Ch. 4) Oxford University Press.

[25]As Mr. Adams believes that he is threatened by government assassins, whereas Ms. Greene thinks that she is threatened by a cabal of Satan-worshiping, child-molesting liberal elites, the contents of his delusions differ from the contents of her conspiracy beliefs. Yet, the considerations presented here would apply even if the contents of Mr. Adams' delusions were similar to the contents of Ms. Greene's conspiracy beliefs, or *vice versa*. Accordingly, I now put this difference between the cases of Mr. Adams and Ms. Greene aside.

[26]As Stout points out, conspiracy theories have been deemed epistemically distinctive in the sense that it is possible to interpret evidence against them as resulting from conspirators' attempts to keep their conspiracies hidden, see Stout, op. cit. note 4, pp. 473–474; and also, for example, Keeley, B. L. (1999). Of conspiracy theories. *The Journal of Philosophy*, *96*(3), 109–126. Yet, as Mr. Adams openly wonders whether his health care provider participates in the government plot he (Mr. Adams) sees there to be against him (Mr. Adams), the cases of Ms. Greene and Mr. Adams are apparently not different from each other in this respect.

[27]See also Stout, op. cit. note 4, p. 475.

[28]See, for example, Davis, G. (2005). Coping with mental illness. *Psychiatric Rehabilitation Journal*, *28*(3), 299–302; Henriksen, M. D., & Parnas, J. (2014). Self-disorders and schizophrenia: A phenomenological reappraisal of poor insight and noncompliance. *Schizophrenia Bulletin*, *40*(3), 542–547. When a person's delusions are based on hallucinations, the person does not meet the DSM-5 criteria of Delusional Disorder. Yet, his delusions can nevertheless be central to his practical identity.

comprehensive worldview. Cases of patients such as Ms. Jordan would plausibly be problematic to surrogate decision-making in similar ways and to a similar degree as cases of otherwise similar patients whose worldviews are based on unwarranted conspiracy beliefs. Hence, even if it were warranted for his surrogate(s) to put Mr. Adams' delusional beliefs aside, contrary to what Stout suggests cases of other deluded patients—patients such as Ms. Jordan, for example—could be importantly different in this respect.

Given that Ms. Jordan's case would be as problematic to surrogate decision-making as the case of an otherwise similar patient whose worldview is based on unwarranted conspiracy beliefs, the feature that makes the patients' cases problematic for surrogate decision-making is plausibly just that the beliefs that ground the patients' worldviews are unwarranted. In other words, that the unwarranted beliefs that ground the latter patient's worldview are conspiracy beliefs plausibly does not make a difference here. There also already exists a significant amount of bioethics debate pertinent to making surrogate decisions in cases of patients whose practical identities are grounded on unwarranted beliefs.[29] And even if more debate were needed on how to make surrogate decisions in their cases—or on how health care providers should assess the decision-making abilities of patients whose capacity is in doubt—the above considerations suggest that the debates need not focus on unwarranted conspiracy theories. For the reasons presented above, Stout's argument does not show that we need extensive bioethics debate over the proper response to the influence that unwarranted conspiracy theories have at the individual level of clinical decision-making. As Stout suggests, the MacArthur model is quite widely used in clinical practice.[30] Yet, the above considerations arguably apply, *mutatis mutandis*, also in connection with the other main standards for determining decision-making capacity.

4 | TWO POSSIBLE OBJECTIONS

A critic might maintain that even if the impacts that unwarranted conspiracy theories have at the individual level of clinical decision-making were not especially difficult to detect or handle, the impacts nevertheless too often remain without adequate attention at the individual level of clinical decision-making. Accordingly, the critic could conclude that, as Stout maintains, the question of how we should respond to the impacts that unwarranted conspiracy theories have in the one-to-one clinical context merits extensive bioethics discussion after all. Now, given the absence of sufficient empirical data on the matter, it is difficult to determine how often the impacts of unwarranted conspiracy theories remain without adequate attention in the clinical context.

Yet, to return to our main examples, it is plausible that treatment refusals such as those of Mr. Adams are commonly deemed invalid in healthcare and that the health care providers facing patients such as Mr. Adams typically resort to surrogate decision-making. And, as proposed, in terms of the patients' capacity to validly refuse the treatments proposed to them, cases of patients such as Ms. Greene are, as Stout proposes, rather clearly similar to cases of patients such as Mr. Adams. Accordingly, it would be quite surprising if health care providers would consider treatment refusals such as that of Ms. Greene valid. Health care providers treating a patient whose practical identity is based on unwarranted conspiracy beliefs are, I venture to suggest, also likely to acknowledge that making a substituted judgment is not as straightforward in such cases as it is when a patient's unwarranted beliefs are not central to his worldview.

But perhaps many health care providers nevertheless consider treatment refusals such as that of Ms. Greene valid or do not duly acknowledge the difficulties that patients whose worldviews are based on unwarranted conspiracy beliefs pose for surrogate decision-making. In any case, extensive bioethics debate on how properly to respond to the influence that unwarranted conspiracy theories have at the individual level of clinical decision-making would not appear to be a proper reaction to the problem. For just advising those health care providers who would not acknowledge the significance of unwarranted conspiracy theories that such theories can be (as) detrimental to patients' decision-making capacity and practical identities (as delusions) would assumedly suffice for dealing with the difficulty.

A critic might still argue that unless there is extensive bioethics debate over how properly to respond to the influence that unwarranted conspiracy theories have at the individual level of clinical decision-making, healthcare personnel are unlikely to realize that patients such as Ms. Greene could benefit from psychological assistance. But, as proposed above, health care providers are likely to acknowledge that patients such as Ms. Greene plausibly suffer from rather severe lack of decision-making capacity. Accordingly, health care providers are, I venture to suggest, also likely to realize that such patients could benefit from psychological assistance. But maybe several health care providers would nevertheless fail to adequately acknowledge that patients such as Ms. Greene could benefit from psychological assistance?

At any rate, extensive bioethics debate over how duly to react to the effects that unwarranted conspiracy theories have at the individual level of clinical decision-making would not seem to be an appropriate response to the difficulty. For merely informing those health care providers who would not realize that patients such as Ms. Greene could benefit from psychological assistance, that such

[29]See, for example, Lantos, J. E. (Ed.). (2021). The ethics of shared decision making. Oxford University Press; Largent, E. A., Clapp, J., Blumenthal-Barby, J. S., Grady, C., McGuire, A. L., Karlawish, J., Grill, J. D., Stites, S. D., & Peterson, A. (2022). Deciding with others: Interdependent decision-making. *Hastings Center Report*, *52*(6), 23–32; Vogelstein, E. (2016). Autonomy and the moral authority of advance directives. *The Journal of Medicine and Philosophy*, *41*(5), 500–520. Wasserman, J. A., & Navin, M. C. (2018). Capacity for preferences: Respecting patients with compromised decision-making. *Hastings Center Report*, *48*(3), 31–39. Stout acknowledges that the cases of patients whose practical identities are based on unwarranted conspiracy beliefs are "in some ways" similar to patients whose practical identities have been profoundly altered by dementia, see Stout, op. cit. note 4, p. 477, note 33.

[30]Stout, op. cit. note 4, p. 475; see also, for example, Palmer, B. W., & Harmell, A. L. (2016). Assessment of healthcare decision-making capacity. *Archives of Clinical Neuropsychology*, *31*(6), 530–540.

assistance could help the patients, would appear to suffice for dealing with the problem. Finally, as the question of what kind of psychological assistance might benefit patients such as Ms. Greene is rather a psychological than a bioethical question, extensive bioethics debate would not appear to be a proper response to that question either. To what extent the psychological responses to the question merit bioethical attention is a topic that must now be postponed for future work.

5 | CONCLUSION

Conspiracy theories have received rather meager attention in bioethics literature and the calls for more bioethical debate on them typically refer to the effects that unwarranted conspiracy theories have in the public health context. An exception here is Nathan Stout, who argues that there is need for extensive bioethics debate on how properly to respond to the impacts that unwarranted conspiracy theories have at the individual level of clinical decision-making. Above, I maintained that duly acknowledging the impacts of conspiracy theories that raise Stout's concern does not require bioethics debate over the proper response to the influence of unwarranted conspiracy theories at the individual level of clinical decision-making. However, outside of the healthcare system, people are often less protected by measures corresponding to the capacity-assessment and surrogate decision-making practices commonly used within the healthcare system. Accordingly, the considerations presented above do not entail that the impacts that unwarranted conspiracy theories have on health care do not merit (further) bioethics debate. Yet, insofar as the above considerations are plausible, bioethics debate on the impacts, a debate that should duly acknowledge that unwarranted conspiracy theories are not the only form of misinformation and disinformation that cause trouble for public health, should focus on the public health context.[31]

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[31]As proposed, a conspiracy theory (related to medicine) may sometimes turn out to be warranted. Yet, as there already is both legislation and bioethics debate pertinent to dealing with misconduct pertaining to healthcare—see, for example, Smajdor, A., Herring, J., & Wheeler, R. (2022). *Oxford handbook of medical ethics and law*. Oxford University Press,—I assume that the main focus of bioethics debate on conspiracy theories should be on unwarranted conspiracy theories.