I Trust You, You're a Doctor

1. Introduction

In his very interesting article in a recent issue of this *Journal* Steve Clarke (1999) examines various views about a patient's trust of a doctor, including Edwin R. DuBose's view (1995), according to which trust in medicine is closely related to religious faith. Clarke finds them unconvincing and provides his own, more elaborate view of trust. In this short reply to Clarke's paper I argue that his view is not compelling because it faces a difficulty that is similar to the one he believes DuBose's view inherits.

2. DuBose's View and Its Problem

DuBose draws a distinction between trust and confidence to argue that a patient's trust of a particular doctor is somewhat similar to religious faith. He writes, 'confidence is a strong conviction or belief based on substantial evidence or logical deduction … [but t]rust is an expectation or belief based on inconclusive evidence' (DuBose 1995, p. 32). Thus he says that trust of a doctor is more like religious faith than confidence.

Clarke rejects DuBose's view that there is a fundamental difference between trust and confidence. Clarke says, given the facts that any doctor is always less than *perfectly* reliable and that it is practically impossible for a patient to rely on a doctor with *complete* certainty there can be no essential difference between trust and confidence, contrary to DuBose's view.

In answering Clarke's point DuBose might distinguish trust from confidence by saying that below a certain level of subjective probability we can no longer be rationally justified in having confidence in a doctor and that decisions to rely on a doctor below this level of subjective probability are to be counted as instances of trust. However, according to Clarke, this idea does not save DeBose's view. For, if that is really DeBose's view, then, according to Clarke, what DuBose calls trust is nothing but 'irrational behaviour; apparent evidence of mental failure' (p. 65).

3. Clarke's View

Clarke examines two more views of trust introduced by Katz (1984) and Veatch (1991) but finds them unsatisfactory also. Subsequently, he introduces his own view , which is based on Gambetta's definition of trust.[1] Clarke's main claim is that 'In making the subjective probability judgments that underpin her decision as to whether or not to trust a doctor, a patient can and should take into account as many relevant factors as it is practical to do within the scope of the time reasonably available to her' (Clarke 1999, p. 68). In a typical case, Clarke says, this will include considering information that falls into one of three broad categories.

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[1] Gambetta defines trust as follows:

> [T]rust is a particular level of subjective probability with which an agent assesses that another agent or group of agents will perform a particular action, both *before* he can monitor such action (or idenpendently of his capacity ever to be able to monitor it) *and* in a context in which it affects *his own* action. (Gambetta 1988, p. 217)

I do not examine this definition in this paper. I accept it for the sake of argument.

The first is information about a doctor's personality and motivational structure. According to Clarke, a patient can obtain information about the doctor's past record, beliefs and dispositions, and use them to make inferences about how the doctor practises medicine. For instance, Clarke says, if a patient knows that a doctor is devoutly religious or ambitious then the patient can make reasonable predictions about how the doctor will practice medicine.

The second is a cultural, institutional and legal framework. According to Clarke, a patient can obtain information about a doctor's peers and the broader culture that the doctor inhabits. For instance, Clarke says, if a patient knows that a doctor is trained and operates in a medical culture that strongly emphasises duty, the patient can be more confident that the doctor's disclosure will not include any significant omissions.

The third is the testimony of a doctor. If a doctor's testimony (diagnosis, prognosis or prescription for treatment) sounds incompatible with a patient's ordinary experience, Clarke says, then there is *prima facie* reason not to trust the doctor. For example, if a doctor explains a patient's symptoms by appealing to the occurrence of satanic possession, then, according to Clarke, unless the patient believes in satanic possessions, the doctor's testimony and disclosure should not be trusted.

In the next section I argue that Clarke's view is unsuccessful.

4. Objection to Clarke's View

It is not entirely clear what exactly Clarke's view is intended to do. One possibility is that his view is meant to describe what most patients do when they decide whether

or not to trust a particular doctor. That is, Clarke's view is a description of how patients, in actual fact, typically come to trust a doctor. The other possibility is that Clarke's view is meant as a normative account of what he thinks patients *should* do when they determine whether or not they can trust a particular doctor. In the following I examine both of these possibilities and argue that Clarke's view is unsatisfactory in either case.

Suppose, first, that the aim of Clarke's view is to describe how patients, in actual fact, typically come to trust a particular doctor. In this case Clarke's view is clearly unsatisfactory. For, in an ordinary situation it is far from true that patients gather such comprehensive and substantial information regarding a particular doctor—i.e. the doctor's religious beliefs, personality, ambition, cultural background, etc.—before they trust a doctor.

Consider, then, the second possibility that Clarke's view is to provide a normative account of what patients *should* do when they are determining whether or not they can trust a particular doctor. Unfortunately, Clarke's view is unsuccessful in this case as well. Even if we set aside the fact that many medical patients are helpless infants and the infirm elderly, most patients do not ordinarily have the ability or opportunity to gather such detailed information about a specific doctor. Clarke might argue that even granting that, they can at least examine the testimony of their doctors during consultations. However, it is usually very difficult for lay people to judge whether or not a particular doctor's explanation is correct. In Clarke's example the doctor explains her/his patient's symptom by appealing to satanic possession. It *is* true that anyone can easily determine whether or not they should trust their doctors when the explanation of what ails them involves satanic possession.

However, in typical situations doctors do not, I presume, provide such an obviously extraordinary explanation. Hence, if Clarke's view is correct then it seems practically impossible, at least for most patients, to trust a doctor with good reason.

Clarke might claim that he does not mean that a patient has to check *everything* in his list when they determine whether or not they can trust a particular doctor. In fact he explicitly says that they need to collect such relevant information "as it is practical to do within the scope of the time reasonably available to [them]" (Clarke 1999, p. 68). However, it seems hardly possible for most patients to collect information about *any* of them within the scope of the time reasonably available to them. Nevertheless, as a matter of fact, most patients do trust their doctors. Then it follows from Clarke's view that most patients have an *irrational* trust of their doctors, which seems very similar to the consequence of DuBose's view—i.e. patients trust a doctor without sufficient evidence—that Clarke rejects. Therefore, if the second interpretation of Clarke's view is correct then his view is as implausible as DuBose's.

5. Conclusion

I have demonstrated the following two things in this paper: (a) If Clark's view is suppose to describe how patients, in actual fact, come to trust a particular doctor in a real situation his view is clearly false; (b) If Clarke's view is supposed to provide a normative account of what patients *should* do when they trust a particular doctor then it shows that most patients in real situations have an irrational trust in their doctors. Clark might accept (b) and its antecedent. But then, as I have shown, Clarke's view is as uncompelling as DuBose's. For, both of them entail that what

people ordinarily call trust is, as DuBose says, nothing but an expectation or belief based on inconclusive evidence.

Clarke, S. (1999), ‘Trust Me, I’m a Doctor’, *Australian Journal of Professional and Applied Ethics*, pp. 61-71.

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