A Duty to Deceive: Placebos in Clinical Practice

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Among medical researchers and clinicians the dominant view is that it is unethical to deceive patients by prescribing a placebo. This opinion is formalized in a recent policy issued by the American Medical Association (AMA [Chicago, IL]). Although placebos can be shown to be always safe, often effective, and sometimes necessary, doctors are now effectively prohibited from using them in clinical practice. I argue that the deceptive administration of placebos is not subject to the same moral objections that face other forms of deception in clinical practice and medical research. Although deception is normally objectionable on the grounds that it limits autonomy and breaches trust, these grounds do not apply to placebos when they are prescribed within appropriate ethical limits. Patients have reason to prefer that doctors can prescribe placebos in ethically responsible ways. Hence, the AMA has an obligation to endorse and to promote the responsible use of deceptive placebos in clinical practice.

Key words: placebo, deception, clinical policy, pain, autonomy

THE AMERICAN MEDICAL ASSOCIATION PLACEBO POLICY

In November 2006, the American Medical Association (AMA) (Chicago, IL) adopted an ethics policy that categorically prohibits the deceptive use of placebos in clinical practice. Specifically, doctors are prohibited from providing “a substance . . . that the physician believes has no specific pharmacological effect upon the condition being treated” (Bostick et al. 2008, 60).

Under this policy, doctors are only permitted to prescribe medicines that they believe will have specific pharmacological effects, unless the patient agrees in advance to receive a placebo. The clinician would be required to explain to the patient what placebos are and the purpose for using them. “In this way,” the policy optimistically states, “the physician respects the patient’s autonomy and fosters a trusting relationship, while the patient still may benefit from the placebo effect” (Bostick et al. 2008, 60).

The AMA’s new provision most likely increases the legal vulnerability of doctors who use placebos (Kolber 2007). They are now more likely to be sued by patients or professionally disciplined. More generally, the AMA policy reflects a widespread opposition to the deceptive prescription of placebos in clinical practice, and a consensus that placebos represent an unjust violation of patients’ autonomy.

In this article, I will offer an argument in favor of allowing deceptive placebos to be used in clinical practice. But in order for placebos to be ethically defensible, it must first be established that they are effective.

DO PLACEBOS WORK?

The placebo effect has been used in clinical medicine, however infrequently, for centuries. Despite this, the question of whether or not such treatments can form an effective treatment is a source of enduring controversy. The best-known scientific data in favor of the usefulness of placebos comes from Beecher’s 1955 meta-study, “The Powerful Placebo.” Beecher found that 35% of psychiatric patients in 15 separate clinical trials experienced some improvement in their symptoms when prescribed only inert medications. Beecher’s study, unfortunately, failed to account for the effect of natural recovery or regression toward the mean, and is no longer considered reliable (Kienle and Kiene 1997).

A review of the recent literature reveals that there is now little agreement regarding the effectiveness of placebos in the treatment of non-psychological symptoms. Hrobjartsson and Gøtzsche (2001) reviewed 130 clinical trials that included both placebo and no-treatment control groups. In accordance with the World Medical Association’s (Ferney-Voltaire, France) guidelines, each trial included patients with conditions that were either minor or that had no effective available treatment (Hrobjartsson and Gøtzsche 2001). They found no significant placebo effect in the treatment of any symptom except for pain—a finding that inspired a wave of placebo skepticism (Greene et al. 2001; Bailar 2001). Kirsch and Scoboria (2001) have objected to this study on two grounds: first, that it considered only somatic and not psychological illnesses, although psychological symptoms are known to be more effectively treated by placebo, and second, that nearly all the placebos considered were so-called effective.
psychological placebos (such as verbal reassurance) rather than sugar pills or saline injections. The study has been criticized on a range of additional methodological grounds (Greene et al. 2001). To date, no study has been performed that provides evidence for the absence of placebo effectiveness while addressing these criticisms, so the matter is not yet settled.

Despite the uncertainty over the efficacy of placebos in the general case, there is a strong and growing consensus on their efficacy as treatments for the unpleasant psychological symptoms that accompany somatic and psychiatric illness: pain, anxiety, and depression (Turner et al. 1994; Schweizer and Rickels 1997; Kirsch and Sapirstein 1999). This consensus is propped up by meta-analyses such as Hrobjartsson and Gotzsche’s (2001), and by new neuroimaging research that shows that placebos activate many of the same neural pathways as active painkiller medications (Petrovic et al. 2002; Hoffman et al. 2005).

It is true that placebos do not offer benefits to every patient, and perhaps they are ineffective in the majority of cases. Thus it would be wrong to prescribe only placebo when some more effective therapy is available. But, as I will demonstrate, patients frequently present with conditions for which placebos, despite their unreliability, are the best available therapy. In these cases, placebos are the only therapy with the potential to make patients better off—even if they are powerless to heal the underlying complaint.

PLACEBOS ARE ALWAYS SAFE

Since placebos are inert, it is natural to expect that they are completely harmless, unlike active medicines that frequently elicit unwanted side effects. In placebo research; however, there is an oft-repeated belief that well-intentioned placebos can have ill effects as well as positive ones.

Becher’s 1955 study made mention of frequent ‘toxic’ side effects from placebo treatments, including headache, abdominal pain, fatigue, and dry mouth. Rosenzweig and colleagues (1993) found in a review of the literature that 19% of subjects treated with placebo experience an ‘adverse event’ along these lines.

But as Kienle and Kiene (1997) point out, these symptoms are experienced by many people even in the absence of any kind of therapy. For example, Green’s 1964 study showed not only that a comparable number of people have these symptoms before any kind of treatment (placebo or otherwise), but that placebos tended on average to reduce their severity. These baseline rates of suffering are rarely accounted for in studies of the adverse effects of placebos. A number of studies have successfully demonstrated that a harmful ‘nocebo’ effect can be generated by deliberately giving subjects an expectation of harm (Hahn 1997). But these studies are nothing like clinical use of placebos, in which a doctor tries to induce an expectation of benefit.

No doubt, an especially distrustful patient might experience a ‘nocebo’ effect when given a sugar pill, as a result of their pessimistic expectations. But such a patient will experience a ‘nocebo’ effect whether the medicine is active or inert. The placebo treatment cannot be blamed for the harm in these cases. There is no reliable evidence to suggest that the beneficent use of placebos is unsafe.

PLACEBOS ARE SOMETIMES THE BEST TREATMENT

If it were always possible to give patients an effective active treatment, placebos would be unnecessary and clearly unethical. It is only worth considering the deceptive use of placebos because sometimes they are the best available treatment.

Of course, placebos are most effective in the treatment of psychological symptoms like pain and anxiety—symptoms for which perfectly good active treatments exist. We have an almost endless variety of analgesics, anxiolytics, and antidepressants at our disposal. Thus, in the most straightforward cases, placebo treatments cannot be justified. But not every case is straightforward, and as we will see, there are a number of cases in which our battery of normally efficacious treatments will be rendered useless.

Some of these cases involve unusual but plausible conjunctures of events. For example, Lichtenberg and colleagues (2004) envisage a case in which a depressed patient is started on a medication at an ineffective dose and immediately improves before the dosage can be increased to a pharmacologically active level. Seeing the patient’s improvement, the doctor continues the medication at the inert dosage as a deceptive placebo. In cases such as this one, to change from placebo to an active medication would confer no benefit, and would only cause the patient to suffer the drug’s unwanted side effects. Of course, it is possible that the placebo is not responsible for the patient’s improvement, in which case the placebo is of no benefit. But since the placebo treatment does no harm, and since it is clear that no active treatment is required, it is reasonable for the doctor to continue the placebo treatment, whether or not it is responsible for the patient’s improvement.

The case of irritable bowel syndrome (IBS) presents another, less exotic example. IBS is a common digestive disorder that causes bloating and gastrointestinal pain, among other symptoms. IBS has no diagnostic test, and no effective cure. Of IBS patients, 30%–50% do not respond at all to the available treatments (Jarcho et al. 2008). IBS is known to have a strong psychiatric component, and the group of patients who do respond to treatment seem to respond to ‘just about anything’: statistically significant recovery effects have been demonstrated using Chinese herbs (Benouis et al. 1998), peppermint oil (Pittler and Ernst 1998), and myorelaxants (Poynard et al. 1994), among many others. It should be noted that in each of these experiments, the placebo group also improved significantly, despite being offered no assurance that they were being prescribed an active medication.

For IBS patients, deceptive placebos are arguably equivalent to the available active medications; for the subset of patients who do not respond to active medications, placebos may be the best treatment available.
Perhaps the most basic case where placebos are the best available treatment is the case of the patient who has refused the available treatments for personal or financial reasons. For example, placebo is known to be effective in treating depression, while active antidepressants are frequently rejected by patients who dislike their side effects. (Cramer and Rosenheck 1998). A patient who refuses treatment altogether will often be worse off than a patient who can be convinced to take a placebo, even in medical research, when—as I will argue later in text—the placebo effect is at its weakest (Ilitis 2004).

Yet the usefulness of placebos is not confined to disorders with no treatment, since there are many patients who have treatable disorders but who are nevertheless untreated. As Thomas (1994) points out, roughly half the time a patient presents himself to a doctor, a firm diagnosis cannot be made. Prescribing active medications, complete with side effects and risks of adverse reactions, is difficult to justify in these cases. In contrast, placebos are always a safe treatment, and they can be of benefit even when a diagnosis cannot be made.

Similarly, real-world medicine abounds with cases in which efficacious medicines exist but are unavailable: in remote areas, severely impoverished areas, during epidemics, or in war zones.

So what are the options? The untreatable patient can be prescribed a placebo, or sent away empty-handed. The latter course of action neglects an opportunity to alleviate the felt discomfort of the patient’s symptoms, and it may leave patients feeling shortchanged.

Of course, that may be worse than sending them away untreated. But when placebos are used in good faith by a doctor who believes no better treatment to be available, it becomes possible to alleviate symptoms that cannot otherwise be alleviated. Since deceptive placebos are sometimes the best treatment, it is possible that they may be prescribed in a manner that is ethically defensible.

IT IS NOW IMPOSSIBLE TO TEST DECEPTIVE PLACEBOS IN A CLINICAL CONTEXT

Ironically, the categorical ban on deception in scientific research involving human subjects has made it impossible to duplicate Beecher’s (1955) results. Modern ethics guidelines such as the World Medical Association’s (2002) Declaration of Helsinki require medical researchers to inform subjects that they may be given placebo instead of active medication.

Most medical research involving placebos compares the effectiveness of placebos with the effectiveness of an active medication; this design is intended as a means of compensating for the placebo effect so that the effectiveness of the active medication can be measured. Often, the placebo control group shows some improvement in symptoms. However, unless a second control group is given no treatment (placebo or otherwise), it is impossible to measure the strength of the placebo effect relative to the rate of natural recovery. This puts placebo research in difficult ethical terrain. If we try to measure the power of the placebo effect in patients who need treatment and who can be treated, it would be unethical to refuse some proportion of the cohort treatment. But if we are to measure the placebo effect in a group who has no need of treatment, then the placebo effect will presumably be weaker since the patients will have no real expectation of a benefit and no motivation to perceive one.

Indeed, according to the Helsinki Declaration, placebos may only be given to subjects with ‘minor’ conditions, or whose major condition has no known effective treatment (WMA 2002). Now, pain and depression are the conditions that placebo is most effective at treating, and there is a range of good efficacious pharmacological therapies for them. Thus, most of the time, there is no justification for the use of placebos in treating these symptoms.

However, as I argued previously, there are frequently cases in clinical medicine in which all efficacious treatments have been refused, or are for practical reasons unavailable. Because these real-world cases exist, we need to know whether placebos are effective. But in the world of clinical research, antidepressants and painkillers are always available, diagnoses can always be made, and it is never the case that placebos are the best available treatment. In this way, the Declaration of Helsinki prevents the study of placebos for treating pain or depression.

Nearly all the research into the efficacy of placebos has related to the use of placebos in a medical research context, where it is made clear to the subjects that the effectiveness of the active medicine is under review and that a placebo may be prescribed, or in a psychological research context, in which the patients are not in need of assistance (and thus not motivated to experience a benefit). If the effectiveness of a placebo depends on the patient’s belief that they are certain to receive an effective, pharmacologically active medication, then we should expect that the placebos would be ineffective in these contexts. In scientific trials, the medications are not usually dispensed by a known and trusted doctor, they are not usually assured that the medication will be effective, and they are often aware that there is a chance the medication will be inert. The placebo effect really has the odds stacked against it in such a scenario.

There are some innovative study designs that aim to generate the maximum placebo effect while remaining within ethical guidelines. For example, Colloca and Benedetti (2005) suggest that the power of the placebo effect can be accurately measured by determining how much of the benefit in an active therapy is due to the placebo effect. In their experiments, patients were told that they might receive an active medication or nothing. Some of the patients were given a dose of painkillers that was visibly administered by a person, and some were given the same dose covertly by a machine. Those who knew they were being treated experienced more of a benefit, presumably because they received both the pharmacological and placebo effects. Kirsch (2003), for one, applauds this design for not requiring the deception of subjects.

While studies like this may succeed in giving accurate measurements of the placebo effect, it is false to suggest
that they eliminate the need for deception. While the patients were told that they may or may not receive an active medication, the hidden administration of medicine is clearly a manipulation designed to lead the patient into a false belief—namely, that she has received nothing. It is a different type of deception, but it is deception nonetheless.

The Declaration of Helsinki requires that subjects are able to withdraw their consent to continue in a study that has already begun (WMA 2002). If the subject is deliberately led into a false belief that she has been given or not given medicine, then she will be unable to make an informed decision on whether or not she should withdraw. Although the Declaration of Helsinki makes no explicit requirement that subjects are never deceived, it should be quite clear that any type of deception interferes with valid, ongoing informed consent.

The placebo effect is a beneficial effect that is generated by the manipulation of patient expectations—either by honest or by dishonest means. To measure the size of the effect, it is thus necessary to have a group of patients with one expectation, and a control group with a different expectation. It is hard to see how any research design could produce these two different groups without deliberately deceiving at least one, hence violating the spirit, if not the letter, of the Helsinki Declaration.

With these points in mind, it must be concluded that an accurate assessment of placebo effectiveness is currently beyond the reach of research that is compliant with ethical guidelines. I do not wish to argue here that this state of affairs should be changed; however, it is important to realize that placebo effectiveness is likely to be underestimated for the foreseeable future.

**IS DECEPTION REQUIRED?**

The AMA’s recent policy provision recommends that doctors use placebos only with the full informed consent of the patient. The policy contends that revealing the inert nature of placebo treatments would not “significantly diminish their clinical effectiveness” (Bostick et al. 2008, 59).

What reason do we have to believe that ‘revealed’ placebos will be effective at all, let alone close in effectiveness to deceptive placebos? There is very little data comparing revealed placebos with those that are prescribed deceptively. The 1965 study of Park and Covi informed 14 ‘neurotic’ patients in simple language that they were receiving a pharmacologically inert substance.

[m]any people with your kind of condition have also been helped by what are sometimes called ‘sugar pills,’ and we feel that a so-called sugar pill may help you, too (Park and Covi 1965, 350).

Most of the subjects reported improved symptoms, and six said they felt sure that they had been given an active medication, in spite of the researchers’ assurances. However, Park and Covi did not have a control group of untreated patients, so the results are unable to compensate for the natural improvement of the patients (Klein 1990). Furthermore, the study did not include a group of patients treated deceptively with placebos, so it is impossible to determine whether revealing the inert nature of the medicine had a detrimental effect. A similar study was conducted by Aulas and Rosner (2003) with similar results and similar limitations.

Taking into account the limitations of these studies, how much faith should we place in the power of a revealed placebo?

There are several different explanations of the origin of the placebo effect. On one view, the effect is created by patients’ expectations. On another, it is generated by classical conditioning, through which patients learn to associate medicine with healing. A third view holds that the effect is produced by ‘wishful thinking’ (Geers et al. 2005b). Each explanation has its adherents and evidence to support it, but there is no conclusive proof that any single one fully explains the phenomenon (Stewart-Williams and Podd 2004).

Whether or not the placebo effect is generated by patient expectations, it is clear that expectations influence the power of the effect. Indeed, the evidence suggests that this expectation of benefit is required for the placebo effect to be fully effective. In psychological experiments, placebo effects almost disappear when subjects are told that there is a chance that they will be given an inactive medication (Vase et al. 2002). Recent evidence shows that optimists are more likely to perceive positive placebo effects, but only if they are deceptively told to expect such an effect (Geers et al. 2005a).

Other evidence indirectly supports the expectation effect. When patients are given placebo morphine instead of placebo aspirin, the placebo effect is increased (Evans 1974). Large pills are more effective than small ones (Kirsch 1997). Injections are more effective than pills (Chaput de Sain-tonge and Herxheimer 1994). If revealed placebos were as effective as deceptive ones, these results would be hard to explain. But if the placebo effect depends on the expectation or anticipation of benefit, these results would be expected, since these variations can serve only to alter the patient’s expectations.

If patient expectations can control the magnitude of the placebo effect, then the AMA is just wrong when it suggests that doctors can reveal the inert nature of placebo treatments without compromising their efficacy. If placebos are to be used in the clinic at all, they ought to be used deceptively.

In any case, as Kolber (2007) points out, if doctors obtain patients’ consent to prescribe placebos without being sure that they will prescribe them, then patients’ expectations of benefit will be reduced whether or not a placebo is ultimately used. It is likely that the effectiveness of non-placebo treatments will also be reduced, in the event that an active treatment is prescribed instead of a placebo (Kolber 2007). There is likely to be a component of placebo effect in every standard treatment, which would be diminished if the doctor called into doubt the effectiveness of a therapy in this way. Worse, by warning the patient that their active medication may be a placebo, a ‘reverse-placebo’ effect may be generated in which the patient’s expectation of
a positive effect is weakened, and hence their perception of the effect is weakened, even when an active treatment is prescribed. Hence the ‘revealed placebo’ should not be considered to be without risk of adverse effects.

**DOES BEDSIDE MANNER MAKE PLACEBOS REDUNDANT?**

The AMA policy claims that the doctor’s bedside manner generates a ‘psychological placebo’ effect that is strong enough to render deceptive placebos redundant.

Physicians can avoid using a placebo, yet produce a placebo-like effect through the skillful use of reassurance and encouragement. In this way, the physician builds respect and trust, promotes the patient-physician relationship, and improves health outcomes (Bostick et al. 2008, 60).

In keeping with this claim, Thomas (1987) found that patients who were given an emphatically (and dishonestly) positive prognosis fared better than those given an honest prognosis. It may be that these emphatic encouragements are as effective as placebo pills, as the AMA suggests. But as Kolber (2007) has argued, there are limits on the amount of reassurance a physician can give before the reassurance itself becomes just as deceptive as prescribing a placebo. When a patient seeks medical attention, it is usually unlikely that he is about to experience a spontaneous improvement in his wellbeing. If the doctor is completely honest with him about his condition, she cannot impart upon him an expectation of such an improvement. And without the expectation of improvement, there can be no ‘placebo-like’ effect.

The real value of deception, whether it is achieved by means of an inert pill or an dishonest word of encouragement, is that it can drive patient expectations higher than an honest prognosis can. The scale of the placebo effect depends partly on the patient’s expectation of benefit, and perhaps on a conditioned association between treatment and benefit. If the doctor is limited to only honest actions, the patient’s expectation of benefit can only be as good as the doctor’s expectation. Honest encouragement, therefore, is limited encouragement.

Perhaps there is little or no additional benefit in prescribing a placebo pill rather than giving a patient a dishonest, positive prognosis. But the placebo pill is no more deceptive and no less beneficial. And the pill is, at least for some doctors, an easier deception to make.

Since the scale of the placebo effect depends partly on expectations of benefit, and possibly also on a conditioned association between treatment and benefit, it is not plausible that honest levels of encouragement and reassurance are as effective as deceptive pharmacological placebos. Of course doctors should always be encouraging and reassuring, but this is not enough to make deception unnecessary in a clinical context. Neither revealed placebos nor warm words/good bedside manner can render deceptive placebos redundant.

There is a deep taboo against deception in clinical practice. But as I will demonstrate, this type of beneficial deception need not be unethical.

**IS THE AMERICAN MEDICAL ASSOCIATION PROHIBITION AGAINST DECEPTIVE PLACEBOS ETHICALLY JUSTIFIED?**

Ethical arguments against deception of patients are usually rooted in the argument that deception limits the patient’s ability to make truly autonomous choices (De Deyn and d’Hooge 1996). The AMA’s placebo policy is similarly designed to promote the autonomy of patients.

Autonomy has become the primary principle that guides medical decision-making in America (Callahan 1996). This focus on autonomy is relatively recent, originating mostly in reaction to the medical experiments that the Nazis performed on their prisoners in the Second World War, which violated subjects’ autonomy by means of force rather than deception (Faden and Beauchamp 1986).

The best-known case of deception in medical research is the Tuskegee Syphilis Study, in which the control group was left untreated despite the fact that effective treatments for syphilis became available over the course of the experiment. Deprived of the information they needed to make good choices about their medical care, the subjects declined and died, unaided by the researchers. They were instrumentalized, used by the researchers as mere resources. Atrocious, harmful deceptions such as those at Tuskegee have underscored a need for strict disclosure requirements to prevent the instrumentalization of research subjects, and protect their autonomy.

There is no doubt that this kind of deception can place unethical limits on patient autonomy, as well as causing direct medical harm. As a general guiding principle, researchers and clinicians should avoid deceiving their subjects or patients. I will argue, however, that placebo deception is a unique case, in which this principle ought to be suspended.

**PLACEBO DECEPTION NEED NOT VIOLATE AUTONOMY**

Kant (1999) argued that our duty to tell the truth should compel us to tell a would-be murderer that his intended victim is hiding in our house. Few people agree that our duty to speak truly is so demanding. In nearly every sphere of life, there are special circumstances in which we accept that deceptive speech is justified. The duty to tell the truth is merely a prima facie duty, not an absolute one. We may lie to protect a child’s feelings when she asks us if she is overweight. We may lie in order to conceal information given to us in confidence. And, as van Wyck (1990) points out, doctors are frequently tempted to lie to patients in order to conceal a truly distressing prognosis.

Tempted though they may be, ethical guidelines do not permit doctors to lie to a patient for any reason. In medical practice, as in scientific research, it is deemed that there are
no exceptions to the rule against deception. The reasons for this are grounded in the imbalance of knowledge between patients and doctors. If the doctor controls the patient’s access to information regarding his diagnosis and treatment options, she effectively controls the choices he can make, limiting his capacity for self-government.

The problem with this is simply that placebo deception, when applied responsibly, is quite unlike the emblematic unethical forms of clinical deception. Responsible placebo prescription cannot limit a patient’s capacity for self-government, even though it is deceptive and, perhaps, coercive.

The deceptive clinical use of placebos is unlike the Tuskegee experiment, in which the patients were led to believe falsely that there was no better treatment for their condition. Doctors ought to prescribe placebos only when no better treatment is available—indeed, if a doctor is willing to give placebo in place of an effective treatment, then her greatest sin is not deception but negligence. If a doctor is willfully negligent, the AMA’s placebo prohibition will likely only drive her to prescribe nothing; in any case, the absence of placebos is unlikely to force her to prescribe the best therapies in cases where she previously prescribed placebos.

Clinical placebo use is also unlike the case of the lysergic acid diethylamide (LSD) trials cited by Faden and Beauchamp (1986), in which patients unknowingly consumed a substance that the researchers knew to be toxic. These patients had a reason to refuse to take the LSD. Placebos are by definition riskless in a pharmacological sense; there is nothing about them that is worth refusing.

In a broader sense, the clinical use of deception placebos is quite unlike the use of deception in any biomedical experiment involving human subjects. Research and clinical practice are not alike. In research, the subjects provide a service (data) to the researchers. If the researchers do anything to the subjects without their express consent, then they are ignoring the wishes of the subjects and treating them as mere means to obtaining the data. By contrast, in the case of clinical practice, a patient can always refuse treatment, even if the treatment is a deceptive placebo. It is thus impossible for a doctor to instrumentalize a patient who presents of her own free will to the clinic, as long as some beneficial treatment is offered in exchange for payment.

Excepting those cases in which the doctor gives placebos as a means to some end other than improving the patient’s wellbeing, the usual objections to deception do not apply to placebo deception. The senses in which placebo deception might diminish patient autonomy are much narrower. There are two possible arguments that can be made in support of the claim that placebos are a threat to autonomy.

The first argument is that when a patient is given placebo deceptively, she is led toward a false belief about what she is putting into her body. If this false belief limits the choices available to her, then it diminishes her ability to determine her medical future, and hence diminishes her autonomy.

But this argument does not hold, provided that the placebos are prescribed within appropriate ethical limits. In the first place, placebos should only be prescribed when there is no other effective available therapy that the patient is willing and able to take. In such cases the placebo cannot prevent the patient from seeking worthwhile alternatives. But such a requirement would protect the patient’s health as well as her autonomy.

Doctors will sometimes be tempted to misuse placebos. Some will prescribe a placebo in order to avoid responsibility for the risks associated with an effective, active medication. Some will default to a prescription of placebo simply because it is easier than settling on a firm diagnosis. These cases constitute abuses of placebo therapies. But these abuses are not peculiar to placebo—it is just as bad, or worse, when a doctor prescribes an ineffective, active medication for these reasons. Like any other therapy, placebos are open to abuse, and it is incumbent on physicians to prescribe them in ways that do not diminish patients’ autonomy or jeopardize their health.

Of course, doctors frequently misdiagnose patients in good faith, and it will sometimes be the case that a doctor falsely believes that there is no better treatment than placebo. In these cases, the prescription of a placebo might stop a patient from seeking a second opinion and receiving a better diagnosis. But again, this risk is not unique to placebos: when a doctor mistakenly proclaims that no effective treatment is available, or when she prescribes the wrong medication, the patient will probably seek no further treatment. In both of these cases it is the misdiagnosis—not the deception—that limits the patient’s ability to obtain optimal care.

There are other strategies that a placebo-prescribing doctor can employ to preserve a patient’s autonomy. For example, if doctors characterize placebos as a source of temporary, symptomatic relief, then they will not prevent the patient from seeking other ineffective therapies, or effective therapies that later become available through advances in science or through a change in the patient’s attitudes or circumstances.

The second argument claims that the patient’s autonomy is diminished through coercion. If a patient is given a placebo deceptively, he is coerced into accepting the doctor’s decision that the placebo is the best treatment, when he might not have agreed with this assessment when fully informed. This argument seems valid on its face, since it is impossible for a patient to refuse a treatment when they are unaware that it has been prescribed.

Coercion is usually thought to reduce autonomy because it allows a doctor to force the patient to accept a treatment they might prefer not to have (Faden and Beauchamp 1986). But placebos are not, strictly speaking, a treatment. They do not counteract the symptoms or underlying mechanisms of an ailment. Rather, they are a form of suggestion, just as encouraging words or reassurance are forms of suggestion. Indeed, many of the placebos reviewed by Hrobjartsson and Gøtzsche (2001) were no more than reassuring words—dubbed “psychological placebos.”
Pharmacological placebos and psychological placebos operate by the same mechanism, so if it is true that pharmacological placebos reduce autonomy, then it should be true that encouragement reduces autonomy as well. The placebo effect is no more or less resistible in these psychological cases than it is when the placebo is a pill. But it would be absurd to suggest that a doctor should seek consent before smiling at a patient and reassuring him. Perhaps there is some weak sense in which these suggestions are coercive, but it is not a kind of coercion that can be prohibited without crippling clinical practice completely.

The elimination of deception is not a universal moral requirement in medicine or in any realm. It is an instrumental policy aimed at improving patient autonomy. Since placebo deception does not diminish patient autonomy when used responsibly, the general prohibition against deceiving patients ought not to be extended into a prohibition against deceptively prescribed placebos.

**BREACHED SOCIAL CONTRACT BETWEEN DOCTOR AND PATIENT**

There is one more argument in favor of prohibiting deceptively prescribed placebo prescription that does not depend on the promotion of patient autonomy.

One reason why patients believe in the efficacy of placebos is that they have a special relationship of trust with their doctor. A doctor who prescribes a placebo, conversely, uses her position of authority and trust to convince the patient that the placebo is a medication.

There are two basic reasons why this breach of trust might be thought to be unethical. First, the breach might be instrumentally bad. If there is some risk that the deception will be discovered (and presumably there will always be some risk) then the doctor risks damaging the relationship that the patient has with every medical practitioner (Kleinman et al. 1994). The practice of medicine depends on this trusting relationship, and the quality of care would be universally diminished if patients became too skeptical about their doctors’ honesty.

Secondly, it can be argued that we should consider the defense of patient trust to be virtuous in its own right. Even if one agrees that a blanket policy against deception goes too far, it is still possible to argue that the presumption against deception ought to be very strong in the case of a needy patient and a trusted doctor.

I am not sure that patients have an expectation of complete honesty from their physicians (at least in the absence of AMA provisions that explicitly mandate it). But even if patients hold this expectation, they ought not to hold it with regard to the deceptive use of placebos. Responsible placebo use, being unlike other forms of clinical deception, bears no risk of making patients worse off, beyond the baseline risks incurred by any other effective therapy. It is a type of deception that patients ought to be thankful for, just as we are thankful when we receive a mendacious compliment from a friend.

Furthermore, as Kolber (2007) points out, the AMA has a role in establishing patients’ expectations and attitudes in addition to its role defining the behavior of physicians. The longer that placebos are explicitly prohibited, the more likely it is that patients will see them as an undesirable, abusive form of treatment. If the AMA explicitly endorsed the use of placebos in clinical practice, it might foster a perception among patients that placebos are a form of deception that is harmless at worst. Forcing clinicians to make their decisions completely transparent to their patients, if anything, sends a message to patients that the doctor is not to be trusted.

**PLACEBOS CANNOT BE USED WITHOUT RISK OF DISCOVERY**

If placebos are to be used ethically, it is not enough to simply eliminate the AMA’s ban on their use. An explicit endorsement of placebo use is required. The reason for this is that placebos cannot be used in a responsible, ethical way, without sometimes disclosing to patients that they have been deceived.

As I mentioned previously, it would be unethical to prescribe placebos when a better, pharmacologically active treatment is available. It would also be unethical to allow a patient to continue taking placebos when a better treatment becomes available. Sometimes, a patient will be prescribed a placebo shortly before a better treatment appears—in these cases, the doctor who prescribed the placebo is obliged to disclose her prior deception to the patient. Sometimes, too, an inquisitive patient’s questioning will force a doctor to admit to prescribing placebos rather than persist in the deception.

In this age of retail and mail-order pharmacies, not to mention online encyclopedias and health discussion groups, it is more difficult to conceal a placebo’s nature from curious patients, especially outside the hospital, where the doctor cannot control the dispensation of medicine. A family doctor cannot write a prescription for ‘placebo’, and at present, pharmaceutical companies do not offer inert substances with misleading labels for this purpose. Especially outside the hospital, these things make it all the more difficult to deceive one’s patients with an inert medication.

If placebos are used with any frequency, it is thus inevitable that the deception of patients will be frequently discovered. A responsible policy for placebo use cannot simply depend on the hope that placebo deception will be left undiscovered by patients. If patients are encouraged to believe that doctors should never deceptively prescribe placebos, then the eventual disclosure of a placebo prescription would very likely damage the relationship between the doctor and the patient.

However, if patients are instead encouraged to understand that placebos are a legitimate treatment that cannot make them worse off, they are unlikely to hold a doctor at fault when she admits that she had earlier prescribed a placebo.
A program of placebo advocacy is thus required if placebos are to be used in a beneficial way. It is an open question whether patients presently object to receiving placebos, but for the reasons I have given, they have good reason to endorse the use of placebos in their treatment. If placebo use were actively publicized and promoted by the AMA rather than prohibited, the ill consequences of discovery would be substantially reduced.

CONCLUSION

I concluded above that it is now impossible to accurately determine the true efficacy of deceptively prescribed placebos. What we can be completely certain of is that placebos are not harmful. A doctor never harms a patient in any pharmacological sense by prescribing placebo. To justify a placebo prohibition like the one adopted by the AMA, it would need to be shown that placebos make patients worse off.

There may be some concern that doctors will prescribe a placebo in place of an active medication in cases where active medications are both available and of benefit. This would indeed constitute negligence on the behalf of the prescribing doctor. However, prohibiting the use of placebos does not ensure that doctors who were inclined to prescribe placebo will instead make a more responsible prescription. Placebos are far from being the only negligent prescription that a doctor can make.

Similarly, as the AMA points out, some doctors may prescribe placebos to a patient simply to mollify her, or to make her easier to manage. Ethically speaking, this is no different from prescribing sedatives to a difficult patient, and a specific placebo prohibition will be neither required nor effective in preventing this second kind of abuse (Bostick et al. 2008).

If neither beneficence nor non-maleficence is served by prohibiting the use of placebos, then the only possible justification of the prohibition must rest on the perception that deceptive placebo prescription threatens patient autonomy. But as I have argued, deception is not always a threat to autonomy, and the kind of deception used in the responsible prescription of placebos is never a threat to patient autonomy. When placebos are prescribed responsibly—that is, when there is no better available course of treatment—the deception does not diminish the patient’s autonomy at all.

The AMA should remove its placebo prohibition and replace it with a policy that sets ethical limits to deceptive placebo use. In order to undo the damage that the current policy—and others like it—have already done, the benefits of deceptive placebos should be advocated to patients, so that placebo use can be revealed when necessary without distressing patients.

When ethical, effective treatments are prohibited, it makes both doctors and patients worse off. It is time to abandon the idea that placebo deception is always unethical in clinical practice.

REFERENCES


