What It Takes to Defend Deceptive Placebo Use

ABSTRACT. A complete defense of deceptive placebo use must address this ethical objection: deceptive placebo use violates patient autonomy, because deceiving a patient about the placebo nature of a proposed treatment prevents her from giving informed consent to the treatment. Unfortunately, this objection isn't always recognized and clearly disambiguated from other ethical concerns. I consider how well several bioethicists who write about placebo use have responded to, or evaded, this objection. I conclude that defenders of deceptive placebo use should, following the lead of Onora O'Neill, argue that deceptive placebo use is compatible with informed consent.

INTRODUCTION

The American Medical Association prohibits physicians from giving placebos to their patients unless the patients are informed of and agree to the use of placebos.1 This prohibition, and the ethics of placebo treatment more generally, have been discussed in numerous recent papers (Finniss, Kaptchuk, Miller, et al. 2010; Shaw 2009; Foddy 2009; Miller and Colloca 2009; Kolber 2007; Blease 2010). Though some bioethicists support the AMA prohibition, others challenge it, arguing that using placebos without patients’ knowledge and consent—that is, using placebos deceptively—can be ethical (Kolber 2007; Foddy 2009).

This paper is about a specific ethical objection to use of placebos by physicians: deceptive placebo use violates patient autonomy, because deceiving a patient about the placebo nature of a proposed treatment prevents her from giving informed consent to the treatment. This is the central autonomy-based objection to deceptive placebo use. Any adequate defense of deceptive placebo use must address this objection. Unfortunately, defenses of deceptive placebo use don’t always engage this autonomy-based objection. Fortunately, there is a promising line of response to the central autonomy-based objection to deceptive placebo use, suggested by Onora O’Neill (1984). Such is my argument in this paper.
Here’s how I proceed: in the second section, I go through some preliminaries about placebos and the ethics of deceptive placebo use. In the third section, I defend my choice of the central autonomy-based objection to deceptive placebo use. In the fourth section, I discuss Adam Kolber’s defense of deceptive placebo use and explain how his arguments fail to adequately engage with the central autonomy-based objection to deceptive placebo use. The objection survives Kolber’s otherwise formidable defense of deceptive placebo use. An explanatory and justificatory burden remains for defenders of deceptive placebo use: in order to justify deceptive placebo use, they must explain how deceptive placebo use doesn’t preclude informed consent. Or, more radically, they must admit that deceptive placebo use precludes fully informed consent but deny the ethical necessity of fully informed consent. David M. Shaw and Mary Rawlinson take this latter tack, as I explain in the fifth section. Onora O’Neill takes the former tack, arguing that deceptive placebo use is compatible with informed consent. O’Neill’s argument, which I take up in the sixth section, is, alas, too thinly sketched to be a persuasive rebuttal to the central autonomy-based objection, but it is a promising direction for future efforts to defend deceptive placebo use.

PRELIMINARIES

What Is a Placebo?

The American Medical Association (AMA) defines a placebo as “a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated.” We should broaden the AMA’s definition of placebos to include not just substances provided to a patient but also procedures—for example, surgery and acupuncture. A procedure is a placebo if the physician who provides it believes it has no specific pharmacological or physiological effect on the condition being treated. For example, if a physician believes that acupuncture has no specific physiological effect on lower back pain but recommends it to his patient for her lower back pain, then he is recommending a placebo treatment.

According to this definition, whether a substance or procedure is a placebo depends on the beliefs of the physician who’s offering it as a treatment. Placebos include procedures the physician believes don’t have a physiological or pharmacological effect on the condition being treated (e.g., aromatherapy); substances that the physician believes are inert (e.g., sugar pills); active drugs that the physician believes aren’t pharmacological...
logically effective for the condition being treated (e.g., an antibiotic for a viral infection); and active drugs at doses too low to be effective (e.g., an antidepressant at a dose the physician believes is too low to have a pharmacological effect on a patient’s depression).

According to this definition, placebos needn’t be inert—an active substance can be used as a placebo (e.g., an antibiotic for a viral infection). Additionally, physicians may believe that placebos are effective treatments—that is, that they will relieve patients’ symptoms or treat their condition—even though they have no specific pharmacological or physiological effect on the condition being treated.

Kinds of Placebo Use

Two main categories of placebo use are the use of placebos as controls in medical research and the use of placebos as part of clinical care. In this paper, we’re focusing on the use of placebos in clinical care and putting aside the (perhaps) ethically distinct case of using placebos in medical research. Health care providers offer placebos to patients for different reasons. It’s useful to identify four categories of placebo use. First, a physician may give a patient a placebo for a diagnostic purpose. Second, a physician may give a patient a placebo in order to relieve the patient’s symptoms or treat his underlying medical condition. For example, Pesach Lichtenberg, Uriel Heresco-Levy, and Uriel Nitzan (2004) describe a case in which a medical team gave a postoperative patient a saline injection to reduce his physical pain (which it did). Third, a physician may give a patient a placebo in order to reduce a patient’s emotional or psychological suffering, even though the placebo isn’t expected to relieve the patient’s symptoms or treat his medical condition. Fourth, a physician may give a patient a placebo just to placate the patient, or to get him out of the physician’s office, or otherwise to make the physician’s life easier, rather than to benefit the patient. This kind of placebo use is considered unethical; the AMA specifically prohibits it; and I’ve never seen it defended in print.6 Only the first (diagnostic) and second (therapeutic) kinds of placebo use are typically defended.

Deceptive Placebo Use

In this paper, we’re considering a particular objection to deceptive placebo use: deceiving a patient about the placebo nature of a proposed treatment prevents her from giving informed consent to the treatment and
thereby violates her autonomy. But what exactly is deceptive placebo use, as opposed to nondeceptive placebo use?

Deceptive placebo use, as I define it, is *when through words or actions, a physician knowingly causes a patient to believe she’s receiving a drug or treatment that has a specific pharmacological or physiological effect on her condition, when in fact she’s receiving a placebo.*

We should distinguish *deception* from *lying.* Lying is a specific kind of deception: stating something to someone as true that one believes to be false with the intention of getting her to believe it’s true. An example of lying is when a physician gives a patient a saline injection and says, “Here, I’m giving you morphine for your pain.”

Deceptive placebo use need not involve lying (Brody 1982, pp. 114–15). A true statement could be used to deceive a patient about the nature of the treatment she’s receiving: if the health care provider knows that the true statement will cause the patient to form a false belief, then she deceives the patient when she makes the true statement. For example, a physician gives a patient a saline injection and says, “Here, I’m giving you this for your pain,” knowing that this will lead the patient to believe that he’s receiving an active pain medication.

The physician deceives the patient about the nature of the treatment he’s receiving: through his words and actions, the physician knowingly causes the patient to believe something about his treatment (i.e., that it’s an active pain medication) that the physician knows to be false. The physician doesn’t explicitly tell the patient he’s receiving an active pain medication; however, what it’s reasonable for the patient to conclude is that he’s getting a substance that the physician believes is an active pain medication. The physician knows that this is the reasonable conclusion for the patient to draw and relies on the patient to draw it.

An example of nondeceptive placebo use is supplied by Damien Finniss and his coauthors:

Consider, for example, the case of a clinician who recommends acupuncture treatment for a patient with chronic low back pain who has not been helped by standard medical therapy. Aware of the results of the recent acupuncture trials, this clinician thinks that acupuncture might work by promoting a placebo response. The clinician might provide the following disclosure to the patient: “I recommend that you try acupuncture. Several large studies have shown that traditional acupuncture is not better than fake acupuncture treatment, but that both of these produce substantially greater symptom improvement in patients with chronic low back pain compared with those
patients who receive no treatment or conventional medical therapy. Although the specific type of needling does not seem to make any difference, it is possible that acupuncture works by a psychological mechanism that promotes self-healing, known as the placebo effect. (Finniss, Kaptchuk, Miller, et al. 2010, p. 692)

In this case, a reasonable conclusion for the patient to draw is that he’s being offered a placebo, since the physician told him the treatment might work by the placebo effect. Hence this is nondeceptive placebo use.

Several objections have been raised to deceptive placebo use. Some of these are objections to all placebo use; others are objections specifically to deceptive placebo use. These objections include:

(1) Placebo use can harm patients by taking the place of effective diagnosis and better treatment (Bok 2002; Powell and Bailey 2009).
(2) Placebos are ineffective and hence should never be used.  
(3) Good bedside manner can achieve the healing effect that placebos achieve, so placebos are unnecessary (Brody 2009; Brody 1980; Brody 1982; Bok 2002; Katz 1984).
(4) Placebos needn’t be given deceptively, because nondeceptive placebo use can be effective (Loeben and Wilfond 1998).
(5) Deceiving patients undermines their trust and confidence in their physicians and in the medical profession (Bok 1974; Bok 2002; Katz 1984; Schwab 2009; AMA 2007; Kanaan 2009; Kleinman, Brown, and Librach 1994).
(6) Deceiving patients is unethical in and of itself (Kleinman, Brown, and Librach 1994).

In this paper, we’re focusing on objection (7). There are various senses in which deceptive placebo use could violate patient autonomy—that is, there are multiple versions of (7). But the central version of the objection is that deceiving a patient about the placebo nature of a proposed treatment prevents her from giving informed consent to the treatment and thereby violates her autonomy. This version of (7) is what I refer to as the central autonomy-based objection to deceptive placebo use.

Before turning to our discussion of objection (7), let’s briefly consider two other objections. According to objection (2), placebos are ineffective and hence should never be used. In fact, there’s evidence that placebos
can have some medical benefit for patients with certain conditions, including pain, nausea, and psychiatric conditions like anxiety and depression (Spiegel, Kraemer, and Carlson 2001; Vase, Riley, and Price 2002; Benedetti 2008; Hróbjartsson and Gøtzsche 2010). There’s evidence that acupuncture is more effective than standard treatment at relieving various kinds of pain (Linde, Streng, Jürgens, et al. 2005; Melchart, Streng, Hoppe, et al. 2005; Brinkhaus, Witt, Jena, et al. 2006; Haake, Müller, Schade-Brittinger, et al. 2007; Miller and Colloca 2009; Suarez-Almazor, Looney, Liu, et al. 2010). Jay C. Fournier and his coauthors (2010) conclude that placebos are as effective as antidepressant medications in relieving mild to moderate depression (but not severe depression). However, in a review of the evidence, Franklin G. Miller and Luana Colloca conclude that “we lack systematic and definitive evidence of clinically significant benefit from placebo treatments . . . with the possible exception of acupuncture” (2009, p. 44).

According to objection (4), placebos needn’t be given deceptively because nondeceptive placebo use can be effective. If it’s true that nondeceptive placebo use is not only effective but as effective as deceptive placebo use, then deceptive placebo use would be unnecessary and therefore unjustifiable.

One review of the evidence concludes that placebos presented as placebos do have a therapeutic effect. In addition, a recent study by Ted Kaptchuk and others (2010) found that irritable bowel syndrome patients who were given placebo pills presented as placebo pills showed significantly more improvement than patients offered no treatment. However, this study compared disclosed placebo use with a no-treatment control but did not compare disclosed placebo use with deceptive placebo use. It hasn’t been shown that disclosed placebos are as effective as placebos that are presented deceptively as active treatments. Unfortunately there’s little direct evidence on this issue.

There is some data comparing patients taking placebos who believe they’re receiving an active substance to patients taking placebos who believe they might be receiving a placebo (because they’ve been told that they’ll be randomly assigned to either a placebo group or an active treatment group). For example, Antonella Pollo and her coauthors (2001) found that patients who believed they might be taking a placebo rather than a powerful painkiller didn’t experience as much pain relief (as measured by requests for additional painkiller) as patients who believed they’re taking powerful painkillers. In a meta-analysis, Ashbjørn Hróbjartsson and Peter
Gøtzsche (2010) found much variability among studies in the size of the placebo effect on various conditions and found larger placebo effects in drug trials that didn’t inform those patients receiving placebos that they might receive a placebo. This suggests that placebos are most effective when they’re affirmatively presented as active treatments.

Bennett Foddy (2009) identifies indirect evidence that disclosed placebos will be less effective than undisclosed evidence. There’s ample evidence that patients benefit more from treatments when they expect more benefit; for example, patients benefit more from larger pills than smaller pills. If patient expectations influence the therapeutic effect of treatments then, Foddy reasons, we should expect disclosed placebos to be less effective than undisclosed placebos, given that patients expect less benefit from placebos than from active treatments.17

In sum, though placebos presented as placebos have been shown to have a clinically significant effect, there isn’t evidence that they’re as effective as placebos passed off, deceptively, as active treatments. Thus, undisclosed placebos might offer a medical benefit to some patients over and above the medical benefit offered by disclosed placebos.

THE CENTRAL AUTONOMY-BASED OBJECTION TO DECEPTIVE PLACEBO USE

By what right do I claim that this objection is the central autonomy-based objection to deceptive placebo use? There are multiple kinds of autonomy recognized by bioethicists as morally significant kinds of patient autonomy and hence multiple senses in which deceptive placebo use might violate patient autonomy. What justifies my claim that this is the central objection?

Informed consent requirements are meant to protect, first and foremost, a specific kind of patient autonomy: the patient’s ability to control which medical treatments she receives by having the opportunity to give informed consent to or refuse medical treatments before receiving them. Informed consent requirements aren’t meant only to protect patient autonomy; they are also meant to protect patients’ interests.18 But insofar as informed consent requirements are meant to protect patient autonomy, it is first and foremost this specific kind of autonomy that they’re meant to protect.19 Irwin Kleinman, Peter Brown, and Larry Librach give a clear expression of this point:

It is standard medical practice to obtain informed consent before embarking on any treatment. . . . The patient’s right to determine his or her health
care is widely recognized in current ethical theory. It is our fundamental respect for individual choice that is expressed by the principle of autonomy (1994, p. 454).

Tom Beauchamp and James Childress demonstrate the centrality of this kind of autonomy in their *Principles of Biomedical Ethics*. Their chapter “Respect for Autonomy” opens: “Respect for the autonomous choices of persons runs as deep in common morality as any principle, but little agreement exists about its nature, scope, or strength” (2002, p. 99). The respect for autonomy under consideration is, first and foremost, respect for autonomous choice. Beauchamp and Childress acknowledge that there’s dispute about what counts as autonomous choice, but the dispute is clearly over what kinds of actual choice count as autonomous choice (e.g., must a choice be reflectively endorsed to count as autonomous choice?), not over whether the relevant notion of autonomous choice is actual choice.20

Onora O’Neill points out that informed consent requirements protect the patient’s right to choose or refuse treatments, and she bemoans the fact that informed consent requirements don’t protect a more substantial kind of autonomy (“individuality or character, about self-mastery, or reflective endorsement, or self-control, or rational reflection, or second-order desires” [2002, p. 37]). O’Neill may be right that informed consent requirements ought to be revised to protect more substantial kinds of autonomy. But the point, for our purposes, is that the kind of autonomy that consent requirements are meant to protect is the patient’s actual choice or refusal of medical treatment.21

For brevity’s sake, let’s refer to this kind of patient autonomy as *autonomy-informed consent*: the patient controls which medical treatments she receives by giving informed consent to medical treatments before receiving them. To respect autonomy-informed consent, then, patients must have the opportunity to give informed consent (though of course, there’s disagreement about what precisely informed consent requires).22

Autonomy-informed consent must be distinguished from other kinds of patient autonomy, such as what we might call *autonomy-hypothetical consent* (the patient receives the medical treatment she would hypothetically choose to receive were she fully informed) and what we might call *autonomy-capacity* (the patient has the capacity for fully autonomous choice and action).

We should also distinguish patient autonomy from autonomy simpliciter. Philosophers recognize various ways in which people can have autonomy (Arpaly 2003, chap. 4; O’Neill 2002, chap. 4). Some kinds of autonomy
are clearly applicable to medical ethics because they’re ethically significant
ways in which patients can have autonomy (for example, autonomy as
actual control over what happens to you). But not all notions of autonomy
are useful concepts for the purposes of medical ethics (for example, the
Kantian notion of autonomy as conformity with the moral law).

In sum, informed consent requirements are meant primarily to protect
autonomy-informed consent, and they protect autonomy-informed consent
by ensuring that patients give informed consent to medical treatments. So
the central notion of autonomy, when considering the ethics of physician
disclosure and patient consent to treatment, is autonomy-informed con-
sent. Hence, the central autonomy-based objection to deceptive placebo use
is that it violates autonomy-informed consent because it prevents patients
from giving fully informed consent to treatment. This central autonomy-
based objection to deceptive placebo use is a staple of the literature (Brody
414; Lichtenberg, Heresco-Levy, and Nitzan 2004, p. 552; Bok 1974,
p. J1; Loeben and Wilfond 1998, pp. 95–96), and a complete defense of
deceptive placebo use must include a persuasive rebuttal of it.

ADAM KOLBER’S AUTONOMY ARGUMENTS

Adam Kolber (2007) gives a particularly impressive and thorough
defense of deceptive placebo use and critique of the AMA policy in his
indispensable paper “A Limited Defense of Clinical Placebo Deception.”
Kolber argues that the AMA’s categorical prohibition of deceptive placebo
use is too broad: he offers several arguments against a categorical prohibi-
tion of deceptive placebo use, and he makes several arguments for deceptive
placebo use. Here I critique two autonomy-based arguments he gives, but
let me emphasize that these flawed arguments concerning autonomy are
just two of the arguments Kolber provides in an otherwise excellent paper.

Kolber argues that deceptive placebo use doesn’t violate all patients’
autonomy (what I call “the first argument”) and argues that deceptive
placebo use increases some patients’ autonomy (what I call “the second
argument”). Both arguments have the same flaw: they conflate autonomy
with preference satisfaction and fail to engage with the central autonomy-
based objection to deceptive placebo use.

In a section entitled “Inconsistent with Some Patients’ Preferences,”
Kolber makes his first argument against the AMA prohibition:
In order for physicians to violate a patient’s autonomy by using deceptive placebos, it must be the case that the patient is opposed to taking a placebo without his consent. That standard autonomy-based argument against therapeutic deception assumes that patients are opposed to being treated with deceptive placebos. As I noted earlier, however, this is not so clear. The limited data suggest that patients may be more placebo-friendly than physicians. (2007, p. 116)

Kolber appears to be arguing:

1. It only violates a patient’s autonomy to receive placebos deceptively if the patient would prefer not to receive placebos deceptively.
2. Some patients prefer to receive placebos deceptively.
3. Therefore, it doesn’t violate all patients’ autonomy to receive placebos deceptively.

This argument has a basic problem: premise one is false. Having your unexpressed preferences about medical treatment met doesn’t amount to having your autonomy respected. We must distinguish being autonomous (having self-control of some sort) from having our preferences met. A patient could be denied control over her medical care yet still receive the treatment that she prefers to receive. For example, a paternalistic and perceptive physician makes all treatment decisions for a patient without even informing the patient of her treatment options and yet makes treatment decisions that match the patient’s preferences. This isn’t a case of respecting the patient’s autonomy; it’s merely a case of giving the patient the treatment she prefers to receive. The fact that a patient’s unexpressed preferences are met doesn’t mean her autonomy is respected because respecting her autonomy requires letting her make an actual informed decision about her treatment.24

Mightn’t Kolber just disagree that respecting autonomy requires letting a patient make an informed decision about her treatment? Kolber might claim that respecting autonomy doesn’t require letting a patient make a treatment decision but merely requires treating her as she’d prefer to be treated. But according to the dominant ethical framework accepted by medical ethicists and the medical community, respect for patient autonomy requires informing patients about potential medical treatments and getting their informed consent to medical treatments. And according to the central objection to deceptive placebo use, deceptive placebo use violates patient autonomy because it prevents patients from giving informed consent to the medical treatments they receive. Arguing that patients prefer to receive
placebos deceptively—that is, prefer not to give informed consent—doesn’t address this central objection to deceptive placebo use.

Kolber’s Second Argument

Kolber’s second argument against the AMA prohibition begins thus:

If indeed some patients would consider deceptive placebo use a valuable therapy for themselves, then it is the autonomous preference of those patients to have the truth about their treatment withheld when doing so is the most therapeutic option. This points to an internal tension in the standard autonomy rationale for prohibiting deceptive placebo use: sometimes, refusal to deceptively use placebos may violate patients’ interests in limited disclosure. (2007, p. 117)

Here Kolber states that if patients would consider getting a placebo deceptively to be a valuable therapy, then it is their “autonomous” preference to be deceived about receiving placebos. It is certainly true that if a patient’s unexpressed or hypothetical preference is to be deceived about receiving placebos, then her unexpressed or hypothetical preference is to be deceived about receiving placebos. But what is gained by referring to this preference as the patient’s “autonomous” preference? Perhaps the phrase “autonomous preference” is meant to imply that respecting a patient’s autonomy requires meeting her unexpressed or hypothetical preferences. However, it’s not true that respecting autonomy requires meeting a patient’s unexpressed or hypothetical preferences. (More precisely, it’s not true that respecting autonomy-informed consent requires meeting a patient’s unexpressed or hypothetical preferences. Kolber is free to define patient autonomy such that respecting patient autonomy requires or consists of having one’s unexpressed or hypothetical preferences met, but that’s a nonstandard notion of patient autonomy.) Respecting someone’s autonomy-informed consent requires letting her actually control what happens to her—specifically, obtaining her actual informed consent to medical treatment—but it doesn’t require meeting her unexpressed or hypothetical preferences.

Kolber next identifies an “internal tension” in the standard autonomy argument for prohibiting deceptive placebo use, namely that the prohibition on deceptive use of placebos “may violate patients’ interests in limited disclosure.” The idea seems to be that some patients prefer to have the truth withheld from them, that deceptive placebo use would meet this preference for limited disclosure, and that therefore prohibiting deceptive
placebo use makes this preference for limited disclosure go unmet. But in what way is this an internal tension in the autonomy argument? This seems straightforwardly a matter of some patients’ preferences regarding disclosure not being met.25

I don’t mean to downplay the significance of patients’ preferences regarding disclosure not being met. It is a legitimate drawback of the prohibition on deceptive placebo use that it makes some patients’ unexpressed preferences for limited disclosure go unmet. However, failing to meet these unexpressed preferences isn’t a violation of patient autonomy as patient autonomy is commonly understood in discussion of consent to medical treatment, and it doesn’t point to an internal tension in the autonomy argument.

Kolber further develops his second argument:

Similarly, physicians who refrain from administering deceptive placebos are imposing a particular view of treatment decision making on their patients. Granted, physicians do not necessarily know which of their patients would be willing to participate in deceptive therapy. As noted earlier, collecting specific patients’ preferences on the matter interferes to some extent with the efficacy of deceptive therapy. However, surely some patients are willing to receive deceptive placebos. If more patients oppose deceptive treatment than are open to it, perhaps we maximize autonomy interests with a categorical prohibition. (2007, p. 118)

Kolber seems to be arguing that a particular kind of decision-making role is imposed on patients—they are given pertinent information and must give informed consent to treatment. Patients don’t get to choose whether or not they have this decision-making role; rather, physicians and the medical community decide for patients that they must have decision-making role. Imposing this decision-making role on patients fails to respect or diminishes some patients’ autonomy.

In what way exactly does imposing this decision-making role on patients fail to respect or diminish their autonomy? Kolber claims that some patients prefer not to have that decision-making role; they prefer not to receive full information and give informed consent to treatment (i.e., they prefer to be given placebos deceptively rather than given placebos openly with full information).

But in what way does it diminish patients’ autonomy to impose on them a decision-making role that they’d prefer not to have? Perhaps Kolber is arguing that when patients who prefer not to have a certain decision-making role are required to have it (i.e., to be fully informed
about treatments and to give informed consent to treatments), then their autonomy is diminished. This line of thought poses a familiar problem: having one’s unexpressed preferences met (i.e., preferences about one’s decision-making role) doesn’t amount to being autonomous with respect to one’s decision-making role. We must carefully distinguish preference satisfaction (i.e., meeting patients’ preferences about their decision-making role) from autonomy (i.e., patients are autonomous with respect to their decision-making role).

Kolber draws our attention to the fact that some patients don’t have the decision-making role they prefer to have. As a result, they don’t get treatment they’d prefer to get (i.e., placebos administered deceptively). This is an important issue, and it deserves consideration in an examination of the ethics of deceptive placebo use. But as Kolber describes the issue—patients don’t have the decision-making role they’d prefer to have—it isn’t an autonomy issue.

Kolber gives the following example to illustrate and support his point:

Consider the following example, where a patient makes clear that she does not want to discuss her prognosis with her physician:

Mrs. B will undergo surgery in two or three days for a malignant tumor of her right breast. She has obviously understood her situation intellectually, but her mood has been rather blasé and she appears to be rather inappropriately minimizing the emotional gravity of her situation. Dr. T’s experience is that women in Mrs. B’s situation who before mastectomy do not experience some grief and at least moderate concern about the physical and cosmetic implications of their operation often have a very severe and depressive post-operative course. Though Mrs. B has insisted that she does not wish to talk about the effects of the surgery, Dr. T talks with her about such effects prior to surgery in order to facilitate her emotional preparation for her impending loss. In this example, Dr. T acts paternalistically by revealing information that Mrs. B does not want to know, at least at present. Dr. T has failed, in effect, to respect Mrs. B’s autonomy, by imposing on her, for entirely therapeutic reasons, what his experience and judgments tells him is best for her. Had Dr. T refrained from pressing her to discuss the operation, he would have better respected her autonomy, though possibly at some cost to the overall well-being of her postoperative self. (2007, p. 117)

Kolber argues that Mrs. B’s autonomy isn’t respected by her physician; I agree. But I disagree that Mrs. B’s case is analogous to the case of patients who’d prefer to receive placebos deceptively but have never expressed that preference to their physicians. Mrs. B attempts to control the decision-
making role that she has: she expresses her wish not to receive information about the effects of the surgery. Her physician thwarts this attempt and imposes a decision-making role on her: he refuses to give her a choice about receiving this information and just gives her the information. Mrs. B’s active attempt to control her decision-making role is actively thwarted by her physician; her physician doesn’t respect her autonomy.

In the cases of deceptive placebo use under consideration, patients might prefer to be given placebos deceptively than be given full information about placebo treatments, but these patients haven’t necessarily expressed this preference. Kolber claims that were these patients given the decision-making role they prefer, this would be a way of maximizing and respecting their autonomy; I disagree. Were these patients given a choice of decision-making role and were their choices honored, this would be a way of maximizing and respecting their autonomy. But merely giving them the decision-making role that they in fact prefer (without giving them a choice, without giving them control over their decision-making role) doesn’t maximize or respect their autonomy but merely meets their preferences.

Therefore, were physicians authorized to give placebos deceptively—that is, were physicians authorized to impose a “limited disclosure” decision-making role on patients rather than an “informed consenter” decision-making role—this would meet the preferences of some patients (i.e., those who prefer to have a limited decision-making role), but it wouldn’t be a boost to the autonomy of any patients.

Though Kolber doesn’t quite pinpoint it, there is an autonomy issue in the neighborhood: patients aren’t allowed to control what kind of decision-making role they have; instead, the role of “informed consenter” is imposed on them. Patients aren’t afforded the ability to control the decision-making role they have by being given the opportunity to choose which decision-making role they have. The informed consent framework protects one kind of patient autonomy, autonomy-informed consent. But imposing the informed consent framework on patients fails to protect another kind of patient autonomy, that of being able to choose what decision-making role they play.

In short, Kolber argues that deceptive placebo use doesn’t violate the autonomy of patients who prefer to be given placebos deceptively and that the prohibition imposes a particular decision-making role on patients, the role of “informed consenter,” thereby diminishing the autonomy of those patients who prefer not to have the decision-making role of “informed consenter.”
I’d describe the situation differently: deceptive placebo use violates the autonomy-informed consent of all patients, because deceptive placebo use denies patients the opportunity to give fully informed consent to the placebo treatment they’re receiving. Imposing the “informed consenter” decision-making role on patients protects the autonomy-informed consent of all patients. But imposing the “informed consenter” decision-making role on all patients prevents all patients from having control over their decision-making role—that is, it prevents all patients from having autonomy vis-à-vis their decision-making role.

Kolber’s arguments are flawed because he conflates autonomy with preference satisfaction: he conflates having one’s autonomy respected with receiving the treatment one prefers, and he conflates having one’s autonomy respected with having the decision-making role one prefers to have. Kolber also conflates one kind of autonomy with another—autonomy-informed consent with autonomy over the decision-making role one plays.

Is there a point to this critique of Kolber, or am I just nit-picking? There is a point—two points, in fact. First, by conflating different kinds of autonomy, and conflating autonomy with other values, Kolber obscures the central autonomy-based objection to deceptive placebo use, that deceptive placebo use violates autonomy because it precludes informed consent to treatment, and Kolber thereby unwittingly fails to address this objection. Second, conflating different kinds of autonomy and conflating autonomy with other values masks real conflicts of values. The real conflicts of values here are between respecting autonomy-informed consent and respecting patients’ decision-making autonomy (that is, allowing patients to determine their decision-making role), between respecting autonomy-informed consent and meeting some patients’ preferences, and between respecting autonomy-informed consent and providing the best treatment to some patients (i.e., deceptive placebo treatment). In working out the ethics of deceptive placebo use, we should reckon with these conflicts between different kinds of autonomy and between autonomy and other values rather than masking them.

EVADING THE CENTRAL AUTONOMY-BASED OBJECTION

In the third section, I made my case that the central autonomy-based objection to deceptive placebo use is the central objection. Of course, some bioethicists question the informed consent framework. They question the feasibility of obtaining informed consent that protects autonomy-informed consent. They question the ethical predominance of autonomy-informed
consent over other kinds of autonomy. And they question the ethical pre-
dominance of autonomy over other values (O’Neill 1984, p. 173). Critics 
of the informed consent framework won’t necessarily find it problematic 
that placebo deception prevents a patient from giving informed consent to 
her treatment—that is, they won’t necessarily accept the central autonomy-
based objection to deceptive placebo use.

This brings us to David M. Shaw and Mary Rawlinson, both of whom 
challenge the informed consent framework and thus who are free to dismiss 
the central autonomy-based objection to deceptive placebo use.

Shaw’s Negatively Informed Consent

Shaw (2009) argues that giving patients placebo treatments without 
informing the patients that the treatments are placebos is consistent with 
respecting patient autonomy—not because it’s consistent with informed 
consent but because respecting patients’ autonomy doesn’t always require 
obtaining informed consent. In this way, Shaw argues for deceptive placebo 
use by arguing for a significant change in the informed consent framework.

Shaw draws on Ulrik Kihlbom’s (2008) proposed alternative to the in-
formed consent system: the “negatively informed consent” (NIC) system. 
According to the NIC protocol, a patient is informed about the purpose 
of a proposed treatment and is informed that it’s possible to receive more 
information if she wants it, but isn’t given full information about the 
proposed treatment; the patient then gives consent to undergo treatment 
and explicitly expresses the wish not to have more information. The 
information that’s withheld from the patient could include the “method 
and means” of the treatment or “all the significant difficulties and risks 
that are likely to occur” with the treatment. Kihlbom argues that seeking 
negatively informed consent from a patient may be preferable, in certain 
cases, to seeking informed consent from her.

Shaw suggests adopting Kihlbom’s NIC system for placebo use: a patient 
would be given some information about the treatment she’s being offered, 
but she wouldn’t be told that it’s a placebo. He proposes specific language 
for physicians to use when offering placebo treatments: “This pill has no 
side-effects, but studies have shown that the more I tell you about how it 
works, the less effective it will be” (2009, p. 98). The patient would also 
be told that she can request more information if she wants it.

Shaw’s NIC protocol gives the patient a choice between receiving full 
information and receiving limited information (and thereby having a 
greater chance of a successful treatment). Shaw asserts that giving the
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patient this choice is sufficient for respecting the patient’s autonomy; respecting the patient’s autonomy doesn’t require giving the patient full information about the treatments in question. 26

I would add that giving the patient a choice between receiving full information and receiving limited information enhances her autonomy in another respect: this choice gives the patient more control over her decision-making role. 27

Mary Rawlinson’s Justification of Deceptive Use

In her 1985 paper “Truth-Telling and Paternalism in the Clinic: Philosophical Reflections on the Use of Placebos in Medical Practice,” Mary Rawlinson argues that it can be justifiable to use placebos deceptively under certain conditions. 28 Deceptive placebo use restores patient autonomy: illness undermines autonomy, and healing illness restores autonomy (1985, 414). It’s the physician’s task to restore the patient’s autonomy by healing illness, and if this healing requires deceiving the patient about her treatment, then that deception might be justifiable.

Rawlinson here presents a nonstandard conception of the physician’s ethical requirements vis-à-vis her patient’s autonomy: the physician has a responsibility to restore the patient’s autonomy. Rawlinson acknowledges that the responsibility to restore autonomy must be balanced against the responsibility to respect the patient’s autonomy by not deceiving her. 29 However, restoring autonomy appears to have priority in this “balancing”: “It must always be the physician’s task to restore autonomy in the patient by releasing him or her from the bondage of illness” (1985, p. 414–15).

As canonically understood, the physician’s requirement is to respect patient autonomy, not restore patient autonomy. The requirement to respect patient autonomy is a constraint on the treatment of patients, not an end of treatment that’s balanced against other ends of treatment (such as the end of restoring patient autonomy). The physician’s responsibility is to provide the best treatment insofar as that’s compatible with respecting the patient’s autonomy, not to provide the best treatment and respect autonomy only insofar that’s compatible with providing the best treatment.

Rawlinson is clear that she’s rejecting canonical views in bioethics—that is, rejecting the informed consent framework and the relative priority it places on respecting autonomy. She argues for a profound change in our understanding of autonomy and paternalism:

I argue that one of the essential effects of illness is precisely an undermining of the patient’s autonomy, and that it ought always to be the physician’s
first aim to restore this loss. I show, however, that the achievement of this
global aim may require in the interim some degree of benevolent paternal-
ism. (1985, p. 404)

Rawlinson—like Shaw—calls for significant reform in how patient
autonomy and consent requirements are understood.

Both Rawlinson’s critique of the informed consent framework and
Shaw’s specific proposal for an alternate consent protocol call for signifi-
cant changes to the status quo. But what if we want to defend deceptive
placebo use in advance of the revolution? This requires working within
the informed consent framework and addressing the central autonomy-
based objection to deceptive placebo use. Luckily, at least one bioethicist
has given it a go.

REBUTTING THE CENTRAL AUTONOMY-BASED OBJECTION

The central autonomy-based objection is that deceiving a patient about
the placebo nature of a proposed treatment prevents her from giving in-
formed consent to the treatment and thereby violates her autonomy. We
can spell out this objection in the form of an argument:

1. Deception about the placebo nature of a treatment prevents the patient
   from giving informed consent to the treatment she receives.
2. When a patient is prevented from giving informed consent to the treat-
   ment she receives or from giving informed refusal to an offered treat-
   ment, her autonomy (i.e., autonomy-informed consent) is violated.
3. Therefore, deception about the placebo nature of a treatment violates
   a patient’s autonomy (i.e., autonomy-informed consent).

In order to rebut this argument, we must argue that premise (1) is false.
That is, we must argue that deceiving a patient about the placebo nature
of a treatment doesn’t prevent the patient from giving informed consent
to the treatment.

Onora O’Neill sketches such an argument in her 1984 paper “Paternal-
ism and Partial Autonomy.” Here O’Neill affirms that respecting patients’
autonomy requires informing them about their treatment and obtaining
their consent. O’Neill also affirms that deceiving a patient about a potential
treatment prevents her from giving informed consent to the treatment and
therefore violates her autonomy.

But, O’Neill points out, patients have limited autonomy and hence
limited ability to give autonomous, informed consent. We must be realistic
about patients’ limited ability to give autonomous, informed consent; we
patients can no more be asked to consent to every aspect of treatment than citizens can be asked to consent to every act of government. Respect for autonomy requires that consent be possible to fundamental aspects of actions and proposals, but allows that consent to trivial and ancillary aspects of action and proposals may be absent or impossible. (1984, p. 176)

She continues:

However, some non-fundamental aspects of treatment to which consent has been given may have to include elements of deception and coercion. Use of placebos or of reassuring but inaccurate accounts of expected pain might sometimes be non-fundamental but indispensable and so permissible deceptions. (1984, p. 176)

With this argument, O’Neill offers a rebuttal to the central autonomy-based objection to deceptive placebo use by arguing that respecting patients’ autonomy requires informing them about their treatment and obtaining their consent but that they need only be informed about the fundamental aspects of their treatment. That a treatment is a placebo isn’t a fundamental aspect of the treatment, so patients needn’t be informed that a treatment is a placebo.30

O’Neill’s line of thought is promising—the most promising line of defense of deceptive placebo use. However, her argument needs to be developed more fully. Specifically, why don’t the “fundamental aspects” include the fact that a treatment is a placebo?

One might try to argue for that conclusion as follows. Patients are regularly informed of the purpose of potential treatments (e.g., a pain medication’s purpose is to relieve lower back pain), the risks of potential treatments and nontreatment (e.g., the pain medication might cause birth defects if you’re pregnant), and the likely benefits and outcomes of treatment and nontreatment (e.g., the pain medication will likely reduce pain in the short run, but the pain might go away by itself without treatment). But patients aren’t regularly informed of the nature of the treatment beyond the bare minimum. For example, the patient who’s prescribed the pain medication might be informed that it reduces pain by reducing inflammation, but she almost certainly won’t be informed of the precise physiological mechanism whereby the medication works. If she’s offered two pain medications—for example Celebrex and ibuprofen—the physi-
cian needn’t explain the different physiological mechanisms whereby each works. She need only explain the risks, benefits, and likely outcomes of taking each. We don’t take physicians to have an obligation to inform patients about the physiological mechanism whereby drugs work, if patients don’t ask. Insofar as there’s an obligation to inform patients about the nature of treatments, this doesn’t seem to require informing them about the physiological mechanism whereby the treatments work. We don’t seem to consider the physiological mechanism whereby a treatment works to be a fundamental aspect of the treatment.

So why would it be a fundamental aspect of a treatment that it might work via a “placebo effect” mechanism rather than another physiological mechanism? Unless we believe in magic or mind-body dualism, there is a physiological mechanism underlying the effective use of placebos; for example, there’s evidence that some placebo pain relief occurs via the same mechanisms involved in opioid pain relief.¹¹ Why would it be a fundamental aspect of a placebo pill that it works via one physiological mechanism (the placebo effect physiological mechanism) rather than another physiological mechanism, when it isn’t a fundamental aspect of ibuprofen or Celebrex that it works via one physiological mechanism rather than another?³²

A potential objection to this argument is that it conflates the (nonfundamental) fact that a pain drug works by one physiological-pharmacological mechanism rather than another with the (possibly fundamental) fact that a placebo pill works by a psychologically driven mechanism rather than a physiological-pharmacological mechanism. Though it might not be a fundamental fact that ibuprofen works via the specific physiological-pharmacological mechanism that it does, it might be a fundamental fact that a pill doesn’t work by a physiological-pharmacological mechanism at all but rather a physiological-psychological one according to this objection. However, the objector owes us an explanation of why it’s a fundamental fact about a treatment that it works via a physiological-psychological mechanism rather than a physiological-pharmacological one. But so, too, is an explanation owed by those who’d claim it isn’t a fundamental fact.

What exactly are the “fundamental aspects” of potential treatments and why are they fundamental? The more pertinent question is: in order to give informed consent, which aspects of a treatment must a patient be informed about (whether or not we call these “fundamental aspects”) and why? On this issue, theories abound. According to a “reasonable patient standard,” what a particular patient must be informed of depends
on what a “reasonable patient” should be informed of. Some versions of the reasonable patient standard are that a patient must be informed about aspects of the treatment that a reasonable patient would wish to be informed about, that she would find relevant, that would likely affect her choice of treatment, or that would be material to making a choice that protects her interests. According to a “subjective standard,” what a particular patient must be informed of depends not on the attitudes of a “reasonable patient” but on that patient’s attitudes—she must be informed about aspects of the treatment that she would wish to be informed about, that she would find relevant, that would likely affect her choice of treatment, or that would be material to making a choice that protects her interests.

On a “reasonable person standard,” whether a patient must be informed that treatments are placebos depends upon whether reasonable patients find it material that a potential treatment is a placebo, whether reasonable patients wish to be informed that a potential treatment is a placebo, and whether the fact that the treatment is a placebo is likely to affect the choice of a reasonable patient or to be relevant to making a choice that protects her interests. In my opinion, these are empirical matters to a large extent. Admittedly, it’s a philosophical question what counts as a “reasonable patient” and not an empirical question—a “reasonable patient” isn’t just the statistically average patient. However, our a priori conception of a reasonable patient should be nonspecific and should be filled in by empirical study of patients’ attitudes. Whether or not a reasonable patient would consider it material that a treatment is a placebo (or would wish to know that a treatment is a placebo or whether it would likely affect her choices) depends in part on actual patients’ attitudes toward placebos—not just physicians’ opinions about what information is important.

If we appeal to a subjective standard rather than a reasonable person standard, physicians will need to know specific patients’ attitudes toward placebos in order to justifiably give them undisclosed placebos. If a physician has a preexisting relationship with a patient, she might already know the patient’s attitudes toward placebos; otherwise she’ll have to ascertain them. Simply asking the patient how he feels about placebos might tip him off that the treatment is a placebo, and if he knows the treatment is a placebo, it might be less effective. Perhaps there are suitable “proxy questions” that physicians can ask patients that are predictive of patients’ attitudes toward placebos but that don’t tip patients off that they’re receiving placebos per se—for example, “Are you open to receiving alternative
or nonconventional treatments?” Whether there are suitable, predictive proxy questions is an empirical issue, depending on how patients conceive of placebos and whether patients’ other attitudes are predictive of their attitudes toward placebos.

Thus, it might be possible to develop an O’Neill-inspired defense of deceptive placebo use—that deceptive placebo use is compatible with informed consent—if we’re able to defend a particular theory of informed consent and gather evidence that patients have the requisite attitudes toward placebos. Unfortunately, there’s little data on patients’ attitudes toward placebos. In a recent study by Guo-Feng Chen and Malcolm H. Johnson (2009) in New Zealand, a majority of patients judged that doctors should provide undisclosed placebos in a variety of situations, though many patients thought that undisclosed placebos should be “a last option” or only used “on rare occasions.” A prior study in Sweden found that 25 percent of patients agreed “completely” or “for the most part” that physicians should give placebos more often, and 63 percent of patients agreed “completely” or “for the most part” that it’s acceptable to give a dying patient a placebo and tell her it’s a cancer treatment, assuming there’s only a small chance she’d discover the truth. More data on patients’ attitudes toward placebos is needed to defend deceptive placebo use. However, in the absence of such data (and in the absence of knowledge of a specific patient’s attitudes toward placebos), the safe assumption for physicians to make is that deceptive placebo use does violate informed consent and violates patient autonomy.

CONCLUSION

I’ve argued here that a persuasive defense of deceptive placebo use must address this central autonomy-based objection to deceptive placebo use: deceptive placebo use violates patient autonomy, because deceiving a patient about the placebo nature of a proposed treatment prevents her from giving informed consent to the treatment. Adam Kolber fails to address this objection. David M. Shaw and Mary Rawlinson evade the objection by challenging the ethical necessity of fully informed consent. Shaw proposes an alternative consent protocol (“negatively informed consent”) for use with placebos. Rawlinson argues that respecting patient autonomy by obtaining fully informed consent isn’t the physician’s primary responsibility but that healing the patient and restoring patient autonomy is. Hence if deceptive placebo use heals the patient, it might be justifiable.
Onora O’Neill accepts the ethical necessity of fully informed consent and argues that deceptive placebo use is compatible with informed consent: placebo deception is compatible with respecting patient autonomy because respecting autonomy requires informing patients only about fundamental aspects of treatment. Fleshing out this argument and gathering the requisite data on patient attitudes toward placebos should be the first concern of defenders of deceptive placebo use.

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NOTES

1. The American Medical Association position on placebo use is given in its code of ethics (AMA 2007): “A placebo is a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated. In the clinical setting, the use of a placebo without the patient’s knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient. Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use. A placebo may still be effective if the patient knows it will be used but cannot identify it and does not know the precise timing of its use. A physician should enlist the patient’s cooperation by explaining that a better understanding of the medical condition could be achieved by evaluating the effects of different medications, including the placebo. The physician need neither identify the placebo nor seek specific consent before its administration. In this way, the physician respects the patient’s autonomy and fosters a trusting relationship, while the patient still may benefit from the placebo effect. A placebo must not be given merely to mollify a difficult patient, because doing so serves the convenience of the physician more than it promotes the patient’s welfare. 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.”

2. This paper concentrates on critiquing Adam Kolber’s defense of deceptive placebo use. Bennett Foddy (2009) has also recently defended deceptive placebo use; his argument was persuasively criticized by Berger (2009), Hester and Talisse (2009) and Kolber (2009).
3. That, I think, is the unexplored subtext of Kolber’s arguments for deceptive placebo use. Beneath his claim that the prohibition on deceptive placebo use diminishes some patients’ autonomy lies a radical challenge to the informed consent framework. Kolber is challenging the dominant conception of patient autonomy and the dominant conception of our ethical requirements vis-à-vis patient autonomy.

4. Recent work on placebos assumes, explicitly or implicitly, a definition of placebos that includes treatments as well as substances (Kolber 2007, p. 83; Miller and Colloca 2009).

5. If the physician believes that a treatment has a specific pharmacological or physiological effect on the condition being treated, then it is not offered as a placebo, whether or not it *does* have a specific pharmacological or physiological effect.

6. See n. 1.

7. For more on this distinction between deception and lying, see Schwab (2009, p. 31).


9. Here is another example of deceptive placebo use: a physician gives a patient a saline injection and says, “This isn’t usually given to someone with your condition, but I think it’ll help you,” knowing that this will lead the patient to believe that he’s receiving an active pain medication. Sissela Bok (2002, p. 55) and Adam Kolber (2007, p. 91) agree with me about these kinds of cases.

10. Ashbjørn Hrjóbartsson and Peter Gøtzsche (2001) give a meta-analysis, and conclude placebos are ineffective, with the possible exception of having a mild effect on pain. Lene Vase, Joseph Riley, and Donald Price (2002), and David Spiegel, Helena Kraemer, and Robert Carlson (2001) criticize the methodology and results of Hrójbartsson and Gøtzsche. Fabrizio Benedetti (2008) summarizes his own and others’ research demonstrating the effectiveness of placebos. Franklin Miller and Luana Colloca (2009) also review the evidence and conclude that “more clinically relevant research is needed before placebo treatments can be recommended as evidence-based therapy, with the possible exception of acupuncture.”

11. There’s evidence that various features of the interaction between providers and patients—for example, physicians’ empathy, warmth and optimism—have a therapeutic effect (Miller and Colloca 2009; Di Blasi, Harkness, Ernst, et al. 2001; Colloca, Lopiano, Lanotte, et al. 2004; Miller, Colloca, and Kaptchuk 2009). However, this evidence doesn’t prove that good bedside manner achieves as *significant* a therapeutic effect as placebos. Kolber (2007)
and Bennett Foddy (2009) dispute the claim that bedside manner alone can achieve the healing effect achieved by placebos.

12. Rawlinson (1985) argues that nondeceptive placebo use can sometimes be effective. In its opinion on placebo use in clinical practice, the AMA Code of Ethics states that placebos can be used openly and still produce a placebo effect (AMA 2007).

13. It’s important to distinguish (7) from (6). According to (6), deceiving a patient is unethical, no matter what the patient is deceived about (the nature of a potential treatment, her condition, her physician’s financial ties to pharmaceutical companies, etc.) and no matter what the consequences of the deception are (harming the patient, helping the patient, etc.). Objection (7) is a more specific objection to deceptive placebo use: it violates patient autonomy.

14. For a contrary view, that antidepressants are more effective than placebos, see Kramer (2011).


17. However, if patients expected as much benefit from placebos as from active treatments, then disclosed placebos should be just as effective as undisclosed placebos; an intriguing possibility for future research is to measure the effect of disclosed placebos on patients who believe placebos are effective treatments.

18. Tom Beauchamp and James Childress identify these multiple purposes of informed consent requirements: “For proponents of autonomy rights for patients, the physician’s obligations to the patient of disclosure, seeking consent, confidentiality and privacy are established primarily (and perhaps exclusively) by the principle of respect for autonomy. Others by contrast ground such obligations on the professional’s obligatory beneficence. The physician’s primary obligation is to act for the patient’s medical benefit, not to promote autonomous decision-making” (2002, p. 272).

19. For example, Albert Jonsen, Mark Siegler, and William Winslade suggest that the recognition of patients’ preferences (which they equate with patient’s choices: “By ‘patient preferences’ we mean the choices that persons make when they are faced with decisions about health and medical treatment”) is meant to protect the patient’s autonomy: “Patient preferences are ethically significant because they manifest the value of personal autonomy that is deeply rooted in our culture. Moral philosophers define the principle of autonomy as the moral right to choose and follow one’s own plan of life and action. Respect for autonomy is the moral attitude that disposes one to refrain from
interference with the autonomous beliefs and actions of others in the pursuit of their goals. It is morally permissible to constrain a person’s freely chosen actions only when that person’s preferences and actions seriously infringe on the rights and welfare of others. The recognition of patient preferences respects the value of personal autonomy in medical care” (1986, pp. 52–53).

20. Beauchamp and Childress explicitly state that autonomous consent must be the individual’s actual choice: “Consent should refer to an individual’s actual choices, not to presumptions about the choices the individual would or should make” (2002, p. 107). See their discussion of this matter on pp. 99–107.

21. In “Paternalism and Partial Autonomy,” O’Neill also points out how some skeptics of the informed consent framework try to shift theoretical attention away from obtaining the informed consent of actual patients to hypothetical consent (what would be consented to). Whether skeptics of the informed consent framework should shift the focus from actual consent to hypothetical consent isn’t our concern here. The point, for our purposes here, is that the dominant notion of autonomy and the kind of autonomy meant to be protected by informed consent requirements—the kind of autonomy that skeptics attempt to shift our attention away from—is autonomy-informed consent (1994, p. 175).

22. For example, bioethicists disagree about exactly what information the patient must have in order to be adequately informed and about whether the physician must facilitate the patient’s understanding of all relevant information or just ensure the patient has access to this information.

23. In “How Placebo Deception Can Infringe Autonomy” (2009), Kolber acknowledges that deceptive placebo use sometimes violates patient autonomy but argues that there are other values at stake and autonomy shouldn’t necessarily be allowed to triumph.

24. Puzzlingly, Kolber clearly understands autonomy to be a matter of self-rule or self-control, not a matter of having one’s unexpressed preferences met. He writes that “the vague and often elusive concept of autonomy ‘refer[s] to . . . self-governance: personal rule of self by adequate understanding while remaining free from controlling interferences by others’” (2007, pp. 114–15). So perhaps my interpretation of Kolber’s argument here is incorrect. An alternate interpretation of Kolber’s argument is: (1) It only violates a patient’s autonomy to receive placebos deceptively if, given the choice, she wouldn’t choose to receive placebos deceptively. However, if she would choose to receive placebos deceptively, given the choice, then receiving a placebo deceptively doesn’t violate her autonomy; (2) Some patients prefer to receive placebos
deceptively, and therefore they would choose to receive placebos deceptively, if they were given the choice; (3) Therefore, it doesn’t violate all patients’ autonomy to receive placebos deceptively. Kolber’s first argument on this interpretation has a similar problem as on my other interpretation of it: the kind of autonomy he’s defending isn’t autonomy-informed consent. Premise 1 makes a claim about autonomy violation: being treated in a certain way (e.g., receiving a placebo deceptively) violates your autonomy only if, given the choice, you wouldn’t choose to be treated that way. What he’s defending rather is autonomy as hypothetical consent: the patient receives the medical treatment (or no treatment) she would hypothetically choose to receive were she fully informed. This kind of autonomy is relevantly different than autonomy-informed consent. When patients are given medical treatments they would consent to but haven’t consented to (i.e., patients are given placebos deceptively, without having the opportunity to consent), their autonomy-hypothetical consent is respected, but their autonomy-informed consent is violated. Thus, Kolber’s claim that “in order for physicians to violate a patient’s autonomy by using deceptive placebos, it must be the case that the patient is opposed to taking a placebo without his consent” is true of autonomy-hypothetical consent but is not true of autonomy-informed consent. When a patient isn’t given the opportunity to make an actual informed choice about her treatment options, her autonomy-informed consent is violated. Though autonomy-hypothetical consent might be a significant kind of autonomy, and a more significant kind of autonomy than autonomy-informed consent, we’re left wanting an explanation of how that might be the case.

25. Speaking of a preference as an “autonomous” preference and speaking of interests being “violated” doesn’t add up to an argument that autonomy has been violated.

26. “Thus NIC maximizes therapeutic potential while continuing to respect patients’ autonomy. In a sense, it maximizes autonomy beyond the normal threshold by allowing access to a wider range of treatments” (Shaw 2009, p. 99).

27. But would using the NIC protocol for placebo use allow for optimal use of placebo? Some researchers think that placebos are more effective when patients don’t know they’re receiving placebos but believe instead they’re receiving active treatments; this is an empirical claim that we’ve very limited evidence for, but the evidence we do have suggests it’s probably true (Miller and Colloca 2009; Kolber 2007). Will patients who consent to receive limited information suspect that they’ve been given placebos, thereby reducing the effectiveness of the placebos? Or will patients assume that they’re receiving
active treatments, resulting in maximally effective use of placebos? These are empirical questions requiring empirical research.  

28. Rawlinson makes the case that placebos can often be used nondeceptively. But when they can’t be used nondeceptively, it is justifiable to use placebos deceptively, so long as several conditions are met (for example, placebo is used only in cases where substantial evidence indicates that it is necessary) (1985, p. pp. 415–416).  

29. Rawlinson acknowledges that the value of restoring autonomy through deceptive action must be balanced against the disvalue of violating autonomy by deceiving the patient (1985, pp. 414–15).  

30. As an anonymous reviewer helpfully pointed out, it’s important to emphasize that O’Neill’s argument doesn’t address the question of whether deception per se—as opposed to withholding nonfundamental information—is acceptable. She argues that withholding nonfundamental information about treatment (e.g., that a treatment is a placebo) doesn’t violate the right to informed consent and so doesn’t violate autonomy in that sense. But it’s still possible that withholding nonfundamental information is morally unacceptable for another reason, namely that it can be deceptive and it’s morally unacceptable to deceive patients about even nonfundamental information. Even if O’Neill successfully argues that undisclosed placebo use doesn’t violate informed consent, we still must argue that undisclosed placebo use isn’t always deceptive or isn’t morally unacceptable when deceptive—for example, by arguing that deceptive placebo use is a “white lie” that can be morally acceptable in the right conditions. However, some bioethicists will dispute the characterization of placebo deception as a “white lie”: on this view, that a treatment is a placebo is important information (Bok 1974).  


32. This argument is inspired by Kihlbom, who writes: “Suppose that I have a severe headache and take a couple of painkillers to get rid of it. To have sufficient understanding for acting autonomously, I surely need to have good grounds for believing the pills will relieve me of my headache. It seems also reasonable that I also should have well-founded negative beliefs . . . that taking them will not bring with them significant risks for side effects. However, I need no positive beliefs of how they chemically work in my brain, to have sufficient knowledge for making an autonomous decision.” Kihlbom doesn’t explicitly mention placebos, but his reasoning provides the raw materials for the above argument that it’s not a fundamental aspect of a treatment that it’s a placebo (2008, p. 148).  

34. Ruth Faden and Tom Beauchamp (1986) endorse a subjective standard according to which a patient must be informed about aspects of a treatment that she would find material.

35. For example, our philosophical description of a “reasonable patient” might be that a reasonable patient is one who makes decisions that promote her best interests consistently with her values and who has the typical attitudes of a patient insofar as there are such typical attitudes and these attitudes don’t impede making decisions that promote best interests consistently with values. Whether a “reasonable patient” considers it material that a treatment’s a placebo will depend in part on typical patients’ attitudes toward placebos, an empirical question.


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