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# Exceptional lies: The ethics of deceptive placebos in clinical settings

## Introduction

A "placebo" can be defined as a medical intervention that, although believed to be inert, is administered *as if* it was an "active" medication. Often, placebos are used to elicit a "placebo effect", that is to say, a modification in patients' health outcomes that is due to the anticipation of some clinical benefits rather than to the specific biochemical properties of the administered treatment. Placebos are thus inherently paradoxical entities, for they are defined as something "inert" and yet capable of causing an "effect". But in addition to the philosophical hurdles associated with the concepts of "placebo" and "placebo effect", the clinical use of placebos also raises a host of ethical issues. In fact, placebos usually require doctors to deceive patients "for their own good" and for this reason, along the history of medicine, they have been variously labeled as the "pious fraud" (Jefferson 1898), the "humble humbug" (Anon 1954) or, more aptly, as medicine's "dirty little secret" (Hollon *et al.* 2002).

In this article I deal only with the ethics of using deceptive placebos in clinical settings. In particular, I will criticize two influential positions within the current placebo debate. The first position is the one according to which deceptive placebos do not raise substantial moral concerns because they can be administered in ways that are "not transparent" and yet "not deceptive". The second position, then, is the one endorsed by the American Medical Association (AMA) according to which the use of deceptive placebos without patients' consent must be categorically prohibited. In what follows I argue that both views are flawed because they equally misrepresent key aspects of the morality of benevolent deception in clinical settings.

Contrary to these positions, I will claim that the use of deceptive placebos is morally permissible, but only in exceptional cases. Before we can discuss the ethics of deceptive placebos in clinical settings, however, it is necessary to look at some empirical data about their clinical effectiveness. Do placebos have clinical effects? And, if yes, are deceptive placebos more useful than disclosed placebos? How often and why do physicians use deceptive placebos in clinical settings? To answer these questions, we shall begin by looking at some empirical findings in the field of placebo studies.

## 1. Do placebos have clinically relevant effects?

In the last decades a converging series of laboratory experiments, clinical trials, and neurocognitive studies has vindicated the existence of placebo effects. Collectively, these studies have shed considerable light on the neurophysiological mechanisms underlying placebo effects (Benedetti 2011). Yet, the extent to which placebos can induce relevant effects in clinical settings is still controversial.

In a series of Cochrane systematic meta-reviews entitled "Placebo interventions for all clinical conditions", Hróbjartsson and Gøtzsche (2001; 2004; 2010) analyzed over 330 trials and concluded that placebo interventions had no "significant clinical effect". Placebos were found to be marginally effective only on outcomes that were subjective (either patient or observer-reported) and continuous – most notably pain. Scholars within the field of placebo studies have criticized these meta-reviews noting, among other thing, that in clinical contexts "placebo effects are likely to be stronger because patients are led to believe that they are receiving an active medication" (Kolber 2007; Howick *et al.* 2013a).

In contrast with the results of these meta-reviews, most of the evidence supporting the case for the clinical effectiveness of placebos is based on the results of high-quality laboratory studies and of experiments conducted in controlled conditions. In particular, in the last two decades, researchers have increasingly resorted to "open-hidden" experiments to separate placebo effects from other variables of the healing context (Colloca *et al.* 2008). In this elegant trial design, the same medication is delivered to patients either in the full view of a clinician who openly describes the procedure and its anticipated effects (expected open administration) or covertly, for example through an intravenous infusion machine (unexpected hidden administration) (Levine and Gordon 1984; Benedetti 1995). The scope of open-hidden experiments is to assess whether it makes a difference to administer a drug while removing some variables from the healing context such as the patient-doctor communication or the bedside presence of caregivers.

In one of these experiments, Amanzio *et al.* (2001) administered four commonly prescribed analgesics to patients in postoperative settings, either in an open or in a hidden way. The study found that the dose of analgesic needed to reduce the pain by half was significantly greater in the hidden administration groups for all four analgesics. Thus, the same dose of a proven analgesic had different effects depending on it being administered in an open or in a hidden manner. Similar effects have been observed with morphine (Bendetti *et al.* 2003a) and in conditions other than pain, such as state anxiety (Benedetti *et al.* 2003a) and Parkinson's disease (Benedetti *et al.* 2003b). In general, open-hidden experiments demonstrate that the effectiveness of therapies depends not only on *what* they are – i.e., their biochemical properties – but also on *how* they are delivered – i.e., the healing context surrounding their administration.

Interestingly, even a single word may sometimes induce dramatically different clinical effects. This has been cleverly demonstrated by a recent trial in which 66 patients with

recurring migraine have been randomized using a 2 x 3 balanced-placebo design. As in a standard Rct, half of the participants received the drug – in this case Maxalt, (10-mg rizatriptan, a proven medication for the relief of headache –, while the other half received an indistinguishable placebo. However, all participants were also randomized to three different information conditions: "Maxalt" (positive information); "Placebo (negative information); and "Maxalt or Placebo" (neutral information). Thus, some participants thought they had a 50% of receiving either Maxalt or the placebo; some participants thought they were receiving Maxalt but received the placebo instead; and some participants thought they were receiving the placebo but received Maxalt instead. The results showed that both the content of the pill and its labelling significantly correlated with the final outcome. Maxalt was superior to placebo when both were correctly labeled. However, the placebo mislabeled "Maxalt" was as effective as Maxalt mislabeled "placebo". Thus this study showed how a single word could lead to significant differences in the effectiveness of both established therapies and placebos.

In sum, a growing body of evidence from laboratory studies and clinical trials supports the claim that placebos may sometimes have significant clinical effects – especially for conditions like pain, depression, migraine, and irritable bowel syndrome (Ibs) (Miller *et al.* 2013). However, these results ought to be interpreted with caution for at least two reasons. First, there are relevant differences between research and clinical contexts and studies suggest that placebo effects are higher in the former setting (Benedetti 2011). Second, placebo effects vary significantly across individuals and healing contexts (Kaptchuk *et al.* 2008; Hall *et al.* 2012). As Miller and Colloca (2009, 317) concluded in a comprehensive review of the literature, "[t]he upshot to date is that we lack systematic and definitive evidence of clinically significant benefit from placebo treatments. Accordingly, more clinically relevant research is needed before placebo treatments can be recommended as evidence-based therapy".

In siding with this latter remark, I shall endorse a cautionary position regarding the clinical effectiveness of placebos based on two assumptions. First, the clinical effectiveness of placebos is likely to be limited to conditions that have strong symptomatic components like pain, Ibs, or depression. Second, the clinical effectiveness of placebos is typically modest but may vary considerably across individuals and healing contexts. Thus, while on the one hand we might have good reasons not to recommend placebos as evidence-based treatments across all clinical settings, on the other hand we may still maintain that placebos are not completely deprived of clinical effectiveness.

## 2. Is deception required for placebos to be clinically useful?

A crucial question concerning placebos is whether they require deception to induce significant placebo effects. Historically, it has been held that placebos must be prescribed

deceptively to be effective. Yet, recent empirical studies on placebos "without deception" have questioned this widely shared assumption (Krueger *et al.* 2006; Sandler and Bodfish 2008; Kaptchuk *et al.* 2010).

In a pilot trial by Kaptchuk *et al.* 2010, patients with Ibs were randomized to receive either no treatment or a placebo pill that was honestly described as containing no active medication (an "open-label placebo"). Patient were read a truthful script about placebo responses and informed about the rationale of the study. Perhaps surprisingly, patients who received the open-label placebo reported statistically significant improvements with respect to the control group. Similar results have been replicated in other pilot studies for recurring migraine (Kam-Hansen *et al.* 2014) and depression (Kelley *et al.* 2012), thus suggesting that "taking a pill" may have beneficial effects even if that pill is not deceptively presented as a medication.

While these studies provide a first proof of principle that placebo effects can be induced not only by deceptive placebos, they do not demonstrate that covert and revealed placebos are equally effective. At present, more research is needed to clarify this empirical issue. Nevertheless, several authors have argued that, given our contemporary understanding of the placebo phenomenon, the burden of proof should be on those advocating the equal effectiveness of disclosed placebos (Kolber 2007; Foddy 2009; Barnhill 2011). In fact, compelling evidence suggests that the magnitude of placebo effects is influenced by the strength of patient's expectations about future clinical benefits (Benedetti 2011). Since placebos affirmatively presented as effective medications are likely to elicit stronger expectations than placebos presented as "inert", it is reasonable to expect that deceptive placebos might offer a medical benefit over and above the one of disclosed placebos (Barnhill 2011).

Furthermore, covertly administered placebos can sometimes be used as diagnostic tools, for example to discriminate real and pseudo-seizures in epileptic patients (see section 5). Clearly, utilizing a revealed placebo in these cases would be self-defeating, as the success of the diagnostic procedure may precisely depends on the patient being convinced that she is assuming a real medication.

Thus, in absence of further evidence, I will assume that deceptive placebos provide patients with greater therapeutic benefits with respect to open-label placebos, and that only deceptive placebos may sometimes act as plausible diagnostic tools.

## 3. How often and why are deceptive placebos used in clinical settings?

Following the initial definition of "placebo", even conventional treatments (e.g., antibiotics) may be used as "placebos" if administered in ways or for conditions for which they are believed to be clinically inert. Accordingly, it is common to distinguish between "pure placebos" (e.g., sugar pills or saline injections) and "impure placebos" (e.g., antibiotics to "treat" a cold) – although this distinction is not always sharp. In the last thirty years several studies have inquired into the attitudes of clinicians toward the clinical use

of pure and impure placebos. In general, these studies indicate that deceptive placebos are still widely administered in clinical settings for a variety of reasons.

A 2004 study found that between 46% and 58% of the contacted U.S. internists and rheumatologists recommended placebo treatments (Tilburt *et al.* 2004). This study also found that nearly half of the participants (46%) admitted of recommending treatments solely for the purpose of enhancing patients' expectations, while 62% considered the use of placebos to be either obligatory or permissible in some circumstances. Interestingly, the study also revealed that doctors use way more impure placebos, such as over-the-counter analgesics, than pure placebos.

The first systematic review (Fässler *et al.* 2010) analyzed 22 studies in 23 articles published between 1973 and 2009 and found that the proportion of health professionals using placebos at least once a year varied between 17% and 80% for pure placebos and between 54% and 57% for impure placebos. The primary motivation to give a placebo was patients' desire to receive a medication, followed by the intention to take advantage of placebo effects, and by the will to avoid revealing that all therapeutic options were exhausted. As for the ethical attitudes, this systematic review found that the majority of health professionals considered the use of placebos morally problematic, but that up to 50% thought that it was acceptable whether it was meant for the patients' good.

A more recent study with 1715 UK doctors found that 97% of the interviewed participants reported having used impure placebos at least once in their career, and that 77% of them admitted of using impure placebos at least once a week (Howick *et al.* 2013b). Common reasons to prescribe placebos were: psychological treatment; because patients requested a therapy; to treat non-specific complains, and to calm patients. This study also investigated more in depth physicians' ethical attitudes, finding that 66% of doctors thought that pure placebos were sometimes ethically permissible; 82% considered deceptive placebos unethical; and that 90% thought that placebos were unethical whenever they jeopardized the doctor-patient trust. Similar attitudes were found with respect to the use impure placebos (84%, 82%, and 94% respectively).

Thus, it appears that deceptive placebos are still widely used in clinical settings for a variety of reasons that include their clinical utility as well as doctors' attempt to satisfy patients' request for a prescription. In general, the vast majority of clinicians use impure rather than pure placebos. Ethical attitudes are polarized, but the majority of clinicians seem to agree that the use of deceptive placebos is morally justifiable in specific circumstances.

## 4. The Ethics of Deceptive Placebos

Deceptive placebos may sometimes be effective for treating conditions such as pain, depression and irritable bowel-syndrome. Since placebos are generally cheaper than tested

medications, one could argue that they provide an appealing and cost-effective therapeutic option. However, placebos often require deception, thus making their use morally questionable in clinical settings.

In the rest of this article I explore the ethics of deceptive placebos, claiming that their use should be considered *prima facie* unethical like any other instance of benevolent deception. To unpack this claim, in the following sections I will criticize two prominent positions within the current placebo debate. The first position aims at avoiding the moral issue of deception by arguing that it is possible to prescribe placebos in ways that are neither "open" nor "deceptive". The second position, then, is the one for which deceptive placebos without patients' consent ought to be categorically prohibited.

*4.1 Can placebos be given in ways that are neither "open" nor "deceptive"?*

Usually, it is assumed that covertly administered placebos involve some form of deception (Bok 1978; Kolber 2007; Miller and Colloca 2009; Foddy 2009; Asai and Kadooka 2013). However, some scholars have recently argued that it is possible to administer placebos in ways that are neither "open" nor "deceptive". As an illustrative example, consider the following way of introducing a placebo to a patient: "I am prescribing you a pill which research suggests can be of benefit to you. In your circumstances I have reason to believe that it will work, with a minimum of side effects" (Gold and Lichtenberg 2014). Is this statement deceptive?

The answer to this question depends in part on how we define "deception". Scholars pursuing this line of argumentation usually define "deception" as to intentionally cause someone "to have a false belief that the deceiver believes to be false" (Carson 2010; Chisholm and Feehan 1977). Hence, deception always requires the instilment of a false belief. However, it is argued, the above statement does not contain or instill any false belief: placebos can be clinically helpful and physicians who are aware of recent studies on placebo effects may sincerely believe so (Cohen and Shapiro 2013; Gold and Lichtenberg 2014). Therefore, the argument goes, it is possible to prescribe placebos in ways that are neither fully "open" nor "deceptive".

While appalling, the view that "non-transparent" placebos are compatible with clinicians' moral obligations is seriously mistaken. Not only the non-transparent use of placebos still qualifies as an act of deception, but it also infringes on patient's autonomy as well as it creates more occasions for doctors to deceive patients.

First, it can be argued that not informing the patient that the prescribed medication is a placebo qualifies as an act of *deception by omission* because the clinician would fail to correct a false belief entertained by the patient, i.e., the belief "that doctors give only active medications" (Chisholm and Feehan 1977). One could reply that clinicians cannot be sure about the beliefs that patients harbor, and thus that they cannot have an intention to deceive by omission. This reply, however, is unconvincing. As Bok noted,

the context in which a therapeutic encounter takes place is not neutral as to the beliefs that both parties can be reasonably expected to entertain: "the doctor's office or hospital room, the impressive terminology, the mystique of the all-powerful physician prescribing the remedy; they convey the impression that the treatment prescribed will have the ingredients necessary to improve the patient's condition. The actions of the physician are therefore deceptive even if the words are so general as not to be lies. Verbal deception may be more direct, but all kinds of deception can be equally misleading" (Bok 1974, 20). Today patients may reasonably expect that all the medicines that doctors prescribe have been tested and approved for their specific efficacy. To contravene this widely shared expectation counts as deception, even if the words uttered by clinicians are sufficiently vague as not be literally false.

Second, advocates of the "non-transparent" use of placebos conceive clinicians' obligations of veracity as if it would only entail an obligation not to lie and deceive. This view, however, is too narrow. Aside from a negative obligation not to lie and deceive, clinicians have also a positive duty to provide truthful information to patients in order to respect they personal autonomy. Arguably, the fact that one is assuming or not an active medication is one of those information that are potentially relevant from a medical point of view. As Kolber observed (2009, 25), "If a person ends up in the emergency room in an unfamiliar locale, he wants to give his treating physician the most accurate information possible about his current medication. With [incomplete] information, the doctor may decline to use highly effective treatments out of fear that it could interact with the medication the patient mistakenly thinks he is taking". The nature of one's medication is clearly an essential piece of information that falls under the duty to inform patients in order to respect their autonomy. Accordingly, clinicians using "non-transparent" placebos would still fall short of their duty of veracity because they would intentionally keep patients in the dark with respect to some relevant medical information.[1]

Third, considering the case of "non-transparent" placebos as distinct from the one of "deceptive" placebos overlooks the fact that lying, deception and dishonest concealment often lay on a continuum, and that in practice one easily tends to "spill over" the other. Let us image the case of a deceptive placebo prescribed only to satisfy patient's request of receiving "something". Assuming that the physician will not be able to write a prescription for a placebo pill to be dispensed by a pharmacy, how will she present the treatment to the patient? How will the bottle be labeled? What if the patient starts asking

[1] In this respect, an interesting option could be that of implementing a strategy of "authorized deception" that would allow the patient to decide and eventually consent in advance to the use of benevolent deception or concealment. In this way, it has been argued, it would be possible to respect not only patients' right to be properly informed, but also their complementary right to decide which information they do not want to receive, i.e. their "right not to know". For a discussion of this option with respect to the use of placebos see Shaw (2009) and Miller *et al.* (2013)

questions about the medication contained in the pills? What if she wants to double-check online what sort of medication she has been prescribed? Even if the initial statement may not be literally deceptive – although it can be *contextually* so – there is always a risk that it will lead to explicitly deceptive practices. Thus, the promotion of non-transparent placebos is often conductive to more dishonest acts on doctors' part.

In sum, the view that it is possible to administer placebos in ways that are neither open nor deceptive is flawed because (i) in today clinical settings the provision of a "non-transparent" placebo qualifies as an act of deception by omission; (ii) clinicians' duty of veracity entails also the positive obligation of truthfully providing all relevant medical information to respect patients' autonomy; (iii) promoting strategic concealment on a wide scale would create more occasions for doctor to deceive. Thus, it is not possible to have the placebo cake and eat it too: either the administration of a placebo is fully open-label, or else it is dishonest and it needs to be justified (or refuted) in some other way.

*4.2 Are deceptive placebos always unethical?*

Current ethical guidelines tend to endorse a policy of "categorical prohibition" with respect to the clinical use of deceptive placebos. For example, in 2006 the American Medical Association (AMA) released its placebo policy in the form of an official "Opinion" in which it stated,

> […] 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 […]

According to this position, in clinical settings it is never permissible to use deceptive placebos without patients' consent. Over the years several commentators have defended similar positions and therefore the AMA Code of Medical Ethics is not alone in advocating a "categorical ban" of deceptive placebos in clinical settings (Asai and Kadooka 2013). Defenders of categorical views do not deny that deceptive placebos may have clinical benefits; rather, they argue that deceptive placebos have a series of short and long-term implications – e.g., for trust, respect of patient's autonomy and patients' or public health – that once factored in justify a categorical ban on their use.

In order to see why the AMA categorical placebo policy stands out with respect to other positions on similar issues, we need to consider how benevolent deception is currently approached in medical ethics. As noted above, today it is acknowledged that clinicians have a general duty of veracity in all their professional communications. This duty is often conceptualized as a *prima facie* duty (Ross 1930; Beauchamp and Childress 2009). *Prima facie* duties are morally binding all things be equal. However, things are not always "equal" and sometimes two *prima facie* duties may conflict. For example, the *prima facie* duty of confidentiality may conflict with the one of preventing harm to third persons –

as in the case of a patient who discloses the intention to murder someone. When two *prima facie* duties conflict, agents should identify and weight the set of reasons supporting each course of action, eventually determining what ought to be done all things considered. Thus, *prima facie* duties indicate the standard moral conduct but allow for exceptions whenever one has compelling reasons to act otherwise.

Conceptualizing doctors' duty of veracity as a *prima facie* duty underscores two important points about how benevolent deception is currently approached in medical ethics. First, there exists a structural moral imbalance between truthfulness and falsehood: other things being equal the former is praiseworthy while the latter is blameworthy. Primarily, falsehood is blameworthy because it threatens patients' trust by undermining doctors' trustworthiness (Pellegrino 1981; Jackson 2001; Hardin 2002), and because it infringes on patient's autonomy and right to informed consent (Beauchamp and Childress 2009). Today the respect for patients' autonomy and the preservation of trust are considered essential conditions for having meaningful therapeutic relationships, and thus the negative moral presumption against deception is held to be rather strong.

Second, although truth telling is crucial for any doctor-patient relationship, there are cases in which other obligations may legitimately override clinicians' *prima facie* duty of veracity. Consider the case of a patient with a ruptured aortic aneurysm who is rushed to the operating theatre. "The anaesthetist knows the patient's chances of survival are poor. Just as preoxygenation is about to begin, the distressed patient asks 'I am going to be all right, aren't I, doctor?" (Sokol 2007, 984). This case presents the doctor with a moral dilemma about benevolent deception: if she replies "You will be ok!" she would tell a lie, but she would not hinder patient's chances of survival; if she tells the truth, instead, she might significantly increase the patient's stress-levels and lower the chances of saving her life. Today this latter option is generally considered undesirable because patients seek the aid of doctors primarily to stay healthy, and not because they want to know "the truth" at all costs. Between the life of a patient and the truth, doctors should always prioritize the former – unless there are very compelling reasons to do otherwise. For this reasons, most scholars believe that whenever the clinical benefits are very high and the harm negligible, benevolent deception may be morally permissible (Beauchamp and Childress 2009; Bok 1978).

But if we acknowledge that clinicians may sometimes legitimately resort to deception, then on what grounds can we justify a categorical ban that applies *only* to deceptive placebos? What distinguishes typical cases of benevolent deception from those in which benevolent deception requires the provision of a placebo? As the reasons against deception based on trust and autonomy are the same in both cases, this difference must concern the balance between the specific benefits and harms of placebos. To further articulate this point we need to consider different ways in which deceptive placebo may harm patients or society.

As for the harm to patients, placebos are always relatively "inert" but never absolutely so. This is true of both "pure" and "impure" placebos, because a placebo is always "a placebo" relatively to a certain condition and according to a certain biomedical theory. Saline injections are not "inert" for rehydrating someone in needs of fluids; sugar pills are not "inert" for people who have diabetes; and lactose tablets are not "inert" for people who are intolerant to lactose. Placebos may have unwanted and sometimes potentially severe side effects. This risk is greater in the case of "impure" placebos: even a homeopathic medicine may unpredictably interact with other substances, and it can always be defective on its own (e.g., the homeopath may have mistakenly used a highly toxic substance in a too high dosage). Furthermore, deceptively administered placebos can sometimes induce psychological addiction (Baumrucker *et al.* 2011). Importantly, prescribing deceptive placebos may lead to overlook present symptoms, thus leaving pathologies undiagnosed (Bok 1978). Patients who "walk away" thinking that they have found an effective medication for they ailments may not look for a second opinion, hence precluding the possibility of undergoing more diagnostic tests.

As for the harm to society, placebos may also have consequences for public health. For instance, using antibiotics as a form of impure placebos might facilitate the creation of antibiotic-resistant bacteria. Also, the cost of unnecessary treatments prescribed as impure placebos is likely to be anything but trivial. As Bok noted (1974, 21) "A great many diagnostic procedures that are known to be unnecessary are undertaken to give patients a sense that efforts are being made on their behalf. Some of these carry risk; many involve discomfort and the expenditure of time and money". If the concept of "placebo" is extended to all kinds of procedures that are unnecessary prescribed to satisfy patients' request "to do something", the costs and harms of unnecessary impure placebos become obvious. Finally, placebos may contribute to the medicalization of society. Prescribing a deceptive placebo to cope with unexplained symptoms promotes the wrong belief that there is "a pill for every ill" (Miller and Colloca 2009), and thus that everything can be cured or treated simply by quaffing some ready-made colored pills.

Therefore, placebos may harm both patients and society. Here, however, it is important to appreciate that this conclusion cannot justify the categorical ban for two reasons. First, deceptive placebos may harm society only if they are widely and consistently used. But if the primary goal of the AMA policy is that of preventing a wide and consistent use of deceptive placebos then the categorical ban is at best superfluous. Given the generally moderate clinical utility of placebos and their implications for trust, autonomy, and health, appealing to clinician's *prima facie* duty of veracity is already sufficient to maintain that deceptive placebos are unethical in the vast majority of the cases. Thus, one cannot justify the enforcement of a categorical ban only by pointing at the possible societal harms of deceptive placebos.

Second, deceptive placebos may harm individual patients, but so does any other medical treatment. Every treatment involves certain risks for patients' health, and these risks are often more serious than those entailed by placebos. At any rate, in both cases the question is not whether certain risks are justified, but whether such risks are justified in relation to the potential benefits. Likewise, the risks of not undertaking further diagnostic exams must always be evaluated in the light of the potential benefits that strategic deception provides in that specific case. Again, the moral issue at stake does not concern just the risks for individual health, but the balance between these risks and the expected benefits. Thus, one cannot justify the categorical ban by pointing only at the harms that deceptive placebos may cause to individual patients.

The question then becomes: does the balance between the harms and benefits of deceptive placebos justify the categorical ban? Here the answer could be "Yes", but only if one assumes that deceptive placebos cannot have substantial clinical benefits. Drawing a parallel with the way in which other cases of benevolent deception are usually approached will clarify this point. As explained above, benevolent deception is often considered unethical in clinical settings. However, there are cases in which the benefits of benevolent deception clearly outweigh its potential harms – like in the one of the "unhopeful anesthetist". These exceptional cases justify the existence of a policy – and of a moral theory – that allows for situational deception.

But if there are no conceivable cases of this kind, then there is no reason to support these policies, or to argue that doctors should have a *prima facie* rather than a categorical duty of veracity. In fact, in absence of such cases, one could argue that a categorical duty is preferable, as it is more straightforward and it would also prevent all the mistakes that doctors might commit in determining what their actual duty is in each case. So, if we cannot image a case in which deceptive placebos have analogous benefits to the case of the "unhopeful anesthetist", then we have no reason to oppose the categorical ban. If this is correct, then much of the rationale supporting the AMA's placebo policy stands of falls with the assumption that deceptive placebos may not have substantial clinical benefits. In the next section, I argue that this assumption is mistaken, as there are cases in which deceptive placebos have both substantial clinical benefits as well as negligible risks for patients and society.

## 5. Defending the use of deceptive placebos for diagnostic purposes

In this section I argue that there are conceivable cases in which deceptive placebos may have substantial clinical benefits and negligible harms.

Following Kolber (2007), let us consider the case of a clinician who is unsure about whether one patient has epilepsy–a neurological disorder that might induce seizures – or a psychological condition that is able to induce epileptic-like pseudoseizures. The doctor

is aware that "[t]he cost of pseudoseizures misdiagnosed as epilepsy can be extremely high, from both a financial and a psychosocial standpoint, with repeated hospitalizations, unnecessary medications, loss of work, loss of driving privileges, and strain on interpersonal relationships all contributing to overall disability" (Slater *et al.* 1995, 580).

There are two effective ways for distinguishing epileptic seizure from pseudoseizures.[2] The first way is electroencephalography. This method is reliable but requires the patient to be actually connected to the machine while she is having a seizure. The problem is that epileptic seizures are episodic and unpredictable, and to monitor a patient for a long time can easily become prohibitively expensive. The second method, then, is to use a deceptive placebo. One study (Slater *et al.* 1995, 582) showed that it is possible to reliably induce pseudoseizures in patients by providing a saline injection introduced by the following script:

> With your permission, we would like to try to bring on one of your events using an injected medication that has been designed to lower seizure threshold. Basically, what the drug does is lover the natural resistance your brain has to having one of your events. It is similar to a medication injected into hospital patients every day, but in your case has been specially prepared to induce seizures. In normal people, the injection does nothing, while in patients with seizures the injection has a greater than 90% chance of bringing on an episode.

The saline injection in this script is a deceptive placebo. This placebo must be deceptive because asking beforehand for patient's consent would deprive the procedure of its diagnostic utility. So, in this situation, is it morally permissible for a doctor to resort to a deceptive placebo in order to diagnose the true nature of patient's seizures?

Analogously to the case of the "unhopeful anesthetist", in answering this question the clinician is confronting a moral dilemma between her duty of veracity and her duty of beneficence. This dilemma appears to be genuine because the use of a deceptive placebo could have substantial benefits for the patient in this case. It can hardly be denied that a correct diagnosis of the nature of the seizure would significantly benefit her, as it would allow for the identification of the best therapeutic path, sparing her significant suffering. Furthermore, it is equally clear that the administration of a single saline injection under medical supervision has negligible risks for patients and public health. Thus there are conceivable cases in which the use of a deceptive placebo may have substantial clinical benefits and negligible risks.

Of course, from the fact that the use of a deceptive placebo might have substantial clinical benefits it does not follow that their use is automatically ethical. As always, the benefits of strategic deception ought to be balanced against not only its harms, but also against its implications for trust and the respect of patient's autonomy. Thus, depending

[2] Medical research may come up with other methodologies to diagnose pseudo-epileptic seizures. However, this scenario would not counter this example, as it would be sufficient to image a situation in which all the conditions of the above example obtain and these newer technologies are unavailable.

on the situation, one might have different reasons to conclude that benevolent deception is or not the best course of action in a specific context. However, the purpose of this example is not to argue for one course of action over another, but only that of demonstrating that there are conceivable cases in which deceptive placebos may have significant clinical benefits and negligible harms.

To be fair, cases like this one may be rare. A deceptive placebo is seldom the only available means at doctors' disposal, and in most of the cases the limited clinical utility of deceptive placebos, together with their implications for trust and the respect of patients' autonomy, does not justify the use of deception. However, such cases may nonetheless occur and we should be careful not to endorse policies that would preclude substantial benefits to patients without a valid reason.

## 6. Conclusions

In the last decades a wave of new empirical discoveries on placebo effects have reignited the ethical debate over the clinical use of deceptive placebos. Amidst all the various positions, in this article my intent has been that of criticizing the view that the ethics of deceptive placebos should be seen as a stand-alone issue, rather than as a special case of the more general problem of providing a normative analysis of benevolent deception in clinical settings. As I have argued, I think that this view is misguided, and that it encourages the elaboration of moral theories and the adoption of policies that are either too permissive or too restrictive with regard to the use of deceptive placebos.

In particular, in this article I have criticized two attempts that are similarly aimed at placing the ethics of deceptive placebos outside the moral framework normally utilized to deal with moral dilemmas about benevolent deception in clinical contexts.

The first view is the one according to which there are ways of administering placebos that defy the traditional dichotomy between truth telling and deception. Here I have argued that such an attempt fails because the non-transparent administration of placebos still qualifies as an act of deception by omission; it disrespects patients' autonomy; and it is conductive to more dishonesty on doctors' part. In general, the view that doctors can exploit a "gray area" in between truthfulness and falsehood is not only fallacious, but it also betrays a limited appreciation of the crucial role that veracity should play in clinical contexts.

The second view that I have criticized is that deceptive placebos present us with a special moral problem that requires an *ad hoc* categorical ban. Here I have argued that categorical views like the AMA's one are justifiable, but only if we concede that deceptive placebos cannot have substantial clinical benefits. By discussing the case of a placebo used for diagnostic purposes, I maintained that this assumption is unwarranted because there are conceivable cases in which the use of deceptive placebos can have substantial clinical benefits and negligible harms.

In contrast to these positions, I have argued that there is no reason to set apart the moral case of deceptive placebos from others cases in which doctors confront moral dilemmas about benevolent deception. Accordingly, in approaching moral dilemmas about the use of deceptive placebos, doctors should rely on the same moral framework they use to approach other dilemmas about benevolent deception. With reference to the current ethical standards, in most clinical contexts this entails that the use of deceptive placebos should be considered as being *prima facie* wrong.

This view poses some serious challenges to the way in which deceptive placebos are currently used, the first of which consists in reducing the number of deceptive placebos currently administered in clinical settings. As empirical surveys reveal, today deceptive placebos are still widely prescribed. However, given their limited clinical utility and their implications for health, trust, and autonomy, in the vast majority of the cases the use of deceptive placebos is unjustifiable and thus unethical. Aside from a few exceptional cases, doctors have no good reason to use deceptive placebos.

Interestingly, enforcing categorical bans does not seem to be an effective measure to prevent clinicians from using deceptive placebos. Here, I suspect, the reason is that among all the problems of clinical ethics, those about truth telling and deception are especially tricky for a number of reasons. First, no one is perfectly honest, and we are all to some extent familiar with the benefits that situational deception may offer; prescribing impure placebos is very easy for doctors, and sometimes it may spare them a lot of time and efforts. Second, those who deceive and those who are deceived tend to appraise the moral implications of the same deceptive act in two dramatically different ways: the deceivers tend to justify and excuse their behavior, while the deceived tend instead to magnify its negative implications. Thus, doctors resorting to deceptive placebos are often in a bad spot to judge their own behavior in impartial ways, as they will naturally tend to discount the moral consequences of their acts.

Against this backdrop, I think that the most promising way of reducing the use of deceptive placebos consists not in enforcing categorical bans, but rather in proactively engaging clinicians in reflecting more about the morality of truth telling and deception. If we believe that doctors could justifiably withhold the truth from patients for their own good in exceptional cases, then we must also make sure that they are properly equipped to recognize, interpret and analyze all the moral implications of their decisions.

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