

## What You Don't Know Can Help You: The Ethics of Placebo Treatment

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**ABSTRACT** *Is it permissible for a doctor or nurse to knowingly administer a placebo in a clinical setting? There is certainly something suspicious about it: placebos are typically said to be 'sham' treatments, with no 'active' properties and so giving a placebo is usually thought to involve tricking or deceiving the patient who expects a genuine treatment. Nonetheless, some physicians have recently suggested that placebo treatments are sometimes the best way to help their patients and can be administered in an honest way. These physicians conclude that placebo treatments are a perfectly acceptable, and ethically unproblematic, mode of treatment.*

*While I grant the common idea that placebos are deceptive is correct, I argue that widespread misunderstandings concerning why this is so has led proponents of placebo treatments to respond to the charge of deception in a way that misses the mark entirely. My goal in this paper, then, is to develop a precise conception of what makes something a placebo, which in turn will clarify the central charge concerning the ethics of placebo treatment, viz. that it is deceptive.*

Is it permissible for a doctor or nurse to knowingly treat a patient with a placebo? There is certainly something suspicious about it: placebos are 'sham' treatments, with no 'active' properties and so giving a placebo involves 'tricking' or 'deceiving' the patient who expects a genuine treatment. I have put the terms 'sham', 'active', 'tricking', 'deceiving' in scare quotes: although I agree that these terms are accurate, the way in which they apply to placebos is not, I shall argue, properly understood.

My goal in this paper, then, is to develop a precise conception of what makes something a placebo, which in turn will clarify the central charge concerning the ethics of placebo treatment, viz. that it is *deceptive*. I think this charge sticks, but the way in which placebo treatments are deceptive is misunderstood by both opponents and proponents of placebo treatment. This misunderstanding has led some proponents to respond to the charge of deception in a way that misses the mark entirely. I conclude by showing that while my arguments provide a strong case against the permissibility of placebo treatment, they do not answer another argument some proponents of placebo treatment make.

### 1. Limiting the Scope: The Placebo in Clinical Practice

#### 1.1. Excluding Placebos in Clinical Research and as 'Lie Detectors'

I want to begin by putting aside two contexts in which placebos might be used. First, I am not interested in the use of placebos in clinical trials. Of course, there are very

interesting ethical issues involved here<sup>1</sup> and any complete account of the role of placebos in medicine would need to deal with them. The reason for splitting off clinical research from clinical practice is just that in clinical research, the healthcare team administering the experimental drug or treatment is not first and foremost motivated by the best interests of each patient in the trial. As Horng and Miller put it:

The randomized, controlled trial is not a form of individualized medical therapy; it is a scientific tool for evaluating treatments in groups of research participants, with the aim of improving the care of patients in the future. Clinical trials are not designed to promote the medical best interests of enrolled patients.<sup>2</sup>

Of course, that the researchers are not motivated primarily by the participant's best interests does not mean that there are no constraints on how participants in clinical trials can be treated: there are and they are quite strict. The point, simply, is that clinical trials, by nature, are not designed to promote the best interests of the individual participants. And so a central ethical question concerning clinical trials, including the use of placebos in such trials, is: What constraints are imposed on the researchers *given* that they are not obliged to act in the patient's best interests?

Such a question does not arise in clinical practice, where the healthcare team is (ideally) motivated only by the best interests of the patient (or what the patient takes to be in her best interests).<sup>3</sup> The question here is not, 'Is it ethical to administer a placebo even if it is against the patient's best interest (as might be the case in a clinical trial)?' but rather, 'Is it ethical to administer a placebo if it *is* in a patient's best interest?' Since this is our central question, I can also put aside cases where placebos are used in a clinical setting to distinguish 'real' from 'unreal' pain or, more strongly, to call the patient out by demonstrating to him that he isn't *really* suffering.<sup>4</sup> Offering a placebo in these cases is not motivated by a concern for the patient's best interests and so they fall outside the scope of my question.

### 1.2. *The Central Question*

The question we are concerned with is simply whether it is permissible to knowingly give a patient a placebo if it is in the best interests of the patient (and the healthcare team is motivated by a concern for the patient's best interests). Some might want to deny that it is *ever* in the best interests of a patient to receive a placebo. This denial could take two forms. First, someone might deny that receiving a placebo is ever in a patient's best interests because placebos don't work. But there is ample evidence — the product of decades of rigorous studies — to support the idea that they do.<sup>5</sup> As such, I will put aside this form of the denial and assume that placebos really can improve someone's condition.

More importantly, we might also understand the denial that it is ever in a patient's best interests to receive a placebo as a conceptual claim. That is, someone might wonder whether there is something *in the very nature* of placebo treatment that always makes it run against a patient's best interests. It is important to see here that if we accept the idea that administering a placebo can improve a patient's health, then the relevant notion of 'best interests' must involve more than the patient's health. That is, the person who wonders whether there is something in the nature of placebo treatment that always runs

counter to a person's best interest need not deny that a placebo can lead to medical improvements. Instead, the claim is that there is some *other* consideration that outweighs, or trumps, whatever benefit of improved health the patient enjoys. I discuss just what that consideration might be below.<sup>6</sup> We can now give a more precise formulation of the question with which this paper began. The central question now is:

**Central Question** Granting that a placebo can improve a patient's health, is there something in the very nature of placebo treatment that *never* makes it in a patient's best interests and so *always* makes placebo treatment impermissible in a clinical setting?

In order to answer this question, or at least understand what is at stake in answering it, we need to understand what makes something a placebo and what the placebo effect is.

## 2. Placebos and the Placebo Effect

### 2.1. Defining 'Placebo' and 'Placebo Effect'

Consider some typical definitions of 'placebo' and the 'placebo effect':

*Placebo* in biomedical research is a substance or procedure that is known to be pharmacologically or physiologically inactive for the condition being evaluated. [...] The *placebo effect* is the sum of psychological or psychophysiological effects occasioned by the use of a placebo.<sup>7</sup>

[The placebo effect is a] change in a patient's condition that results from symbolic aspects of the encounter with a healer or with a healing setting, and not from the pharmacological or physiological properties of any remedy used.<sup>8</sup>

Placebo effects can be defined as the positive physiological or psychological changes associated with the use of inert medication, sham procedures, or therapeutic symbols within a healthcare encounter.<sup>9</sup>

One thing that is striking about these definitions is that they claim that placebos are 'inert', or 'pharmacologically and physiologically inactive', or devoid of relevant 'pharmacological or physiological properties'. But there is a straightforward sense in which these claims are false since these very same definitions acknowledge what research has shown: placebos *can* induce physiological changes in a patient.<sup>10</sup> Consider two famous examples:<sup>11</sup>

1. In 1959 L. A. Cobb's team 'carried out a double-blind trial with sham operations on 19 patients with angina treated with ligation of the internal mammary artery. There was no difference between the two groups, most of whom showed a marked improvement of their angina and exercise tolerance and some of whom improved the shape of their electrocardiograms'.
2. In 1998 I. Hashish's team 'examined the effect of ultrasound on the pain and trismus and swelling which follow wisdom tooth extraction. Wishing to determine the effective dose they found that the ultrasound machine was equally effective whether the machine was turned on or not, provided that the patient and therapist believed it was emitting sound'.<sup>12</sup>

But beyond empirical evidence supporting the conclusion that placebos can induce physiological changes, there are conceptual reasons for thinking so as well. There is no doubt that placebos can effectively treat what we ordinarily identify as psychological conditions. If we think that the psychological supervenes on the physical, and so also on the physiological, then anything we identify primarily as a psychological change brought about by a placebo will entail some sort of physiological change as well.<sup>13</sup> As such, it just seems trivially true that any successful placebo treatment will involve some physiological change even when we describe the patient's ailment and resulting improvement in purely psychological terms.<sup>14</sup>

We might make sense of the tension in the definitions by noting that they do not deny that placebos can induce physiological changes. Instead, what they deny is that these changes come from any relevant physiological or pharmacological property of the placebo. The idea seems to be that while placebos can induce physiological changes, they do not have any physiological properties, but that non-placebos, which also induce physiological changes, do. But now we might wonder why. If both placebos and non-placebos can induce physiological changes, on what grounds can we conclude that the second has physiological properties while the first does not?

I don't mean to deny that there is something to this way of understanding the difference between placebos and non-placebos. But what I want to emphasize is that the question of whether a treatment has physiological properties cannot, on its own, provide the *criterion* for distinguishing placebos from non-placebos because both can be physiologically effective. And in that sense both placebos and non-placebos have physiological properties. Thus, when we classify a treatment as a placebo because it has no physiological properties, our judgment cannot depend on whether it induces physiological changes since both placebos and non-placebos do that. And this means that if we want to define placebos in terms of a lack of physiological properties, we have conceptual work to do because we don't yet know what it means for a treatment to have, or lack, physiological properties in the relevant sense.

There are two ways we can proceed from here. First, we can attempt to develop a conception of physiological properties that does not depend on whether or not a treatment induces physiological changes and then use that conception to distinguish placebos from non-placebos. Second, we can abandon the attempt to understand the difference between placebos and non-placebos in terms of physiological properties. If we adopt this second strategy, we can admit that both placebos and non-placebos have physiological properties where that just means that they can both effectively induce relevant physiological changes (and that is surely the most intuitive way of determining whether something has physiological properties). The difference between placebos and non-placebos, then, will be found in *how* or *why* they are able to be physiologically effective.

## 2.2. *A Broad Definition: The Placebo as a Causal, Cognitive Mechanism*

Following the second strategy, the difference between placebos and non-placebos emerges when we consider how non-placebos work. Consider what happens when someone with diabetes injects insulin. Her body is unable to produce its own insulin and so her cells are unable to take up glucose from the blood stream which, if left unabsorbed in sufficient quantities, will effectively poison her. When injected subcutaneously, insulin

allows cells to take up glucose so that it can be used for energy, thereby fuelling the body of the person with diabetes and treating the her hyperglycaemia. The biochemical details don't really matter here. What I want to draw attention to with this example is that the treatment (the insulin injection) works through a causal, *non-cognitive* mechanism. What does that mean? The idea simply is that the efficacy of the insulin in no way depends on the state of mind of the diabetic. More specifically, it in no way depends on any of the diabetic's intentional attitudes — the insulin will work regardless of the diabetic's beliefs, desires, wishes, hopes, fears about the insulin or anything else.

The same is not true for placebos, which operate through a causal, *cognitive* mechanism. What I mean by this is that placebos operate by way of an essentially psychological mechanism: an explanation of their efficacy must necessarily invoke some subset of the patient's beliefs, desires, hopes — in short, some subset of the patient's intentional attitudes. This involves far more than the thought that the treatment *results* in changes that can only be adequately understood in psychological terms — a lobotomy would count as a placebo on this understanding of what makes something a placebo. Instead, the idea is that the result itself — whether psychological or merely physiological — cannot be explained as having come about without reference to some subset of the patient's intentional attitudes.

It should be clear by now that this does not mean that the placebo effect is a purely psychological one (if that even makes sense): placebos can induce genuine physiological changes as well. What it means is that a placebo's efficacy essentially involves psychological, or cognitive, categories. Unlike with insulin, a story about how a placebo works must include information about a patient's state of mind. To be clear, I am proposing this as an initial *constitutive criterion* for classifying a treatment as a placebo. This means that if the effectiveness of a treatment we initially thought was a placebo can be adequately explained in purely physiological terms, then we are not in fact dealing with a placebo. Of course, given the supervenience thesis mentioned above, *some* physiological explanation will always be possible. It may, however, be inadequate in the sense that it fails to make the right kind of sense of the change that occurs. I am assuming here, without argument, that there are certain domains, the mental being one, where reductive or eliminative explanations will not (usually) be adequate. The question, then, of whether something has physiological properties is neither here nor there. The relevant question is whether the treatment's efficacy is essentially effected through psychological or cognitive mechanisms.

Now this understanding of the distinction between placebos and non-placebos will only do as a first pass, since it seems to cast the 'placebo' net too widely. If a placebo is a treatment that induces a cure through a psychological mechanism, then any treatment that aims to improve a patient's health by altering his state of mind will count as a placebo and the success of these treatments will count as an instance of the placebo effect. This will include everything from psychotherapy to relaxation techniques to a friendly bedside manner — all of which, in the right circumstances, can substantially improve a patient's health. Some people are happy to accept this and simply identify the kinds of effects a positive clinician-patient interaction can have on a patient's health as the placebo effect.<sup>15</sup> Others are uncomfortable with the idea that psychotherapy and good bedside manner should be understood as placebos, while embracing the central idea that what defines a treatment as a placebo is the fact that it operates through psychological mechanisms. They solve the problem by insisting that something can only

count as a placebo if it is being offered as an alternative to an effective therapeutic intervention. And since there is no such alternative in the case of psychotherapy or good bedside manner, these interventions do not count as placebos.<sup>16</sup>

I am suspicious of a conception of the placebo and the placebo effect that classifies psychotherapy and good bedside manner as placebos.<sup>17</sup> But I think we can restrict the class of treatments we want to call placebos without imposing the *ad hoc* requirement that something is a placebo only if there is a non-placebo alternative. Instead, I think we can isolate the nature of the placebo by understanding the nature of the psychological mechanism through which it operates. In doing so, the reason for our feelings of unease with the idea of placebo treatment emerges rather clearly.

### 2.3. *Narrowing the Definition: Placebos as Expectation*

We know that one defining feature of placebos is that they operate through a psychological mechanism. But we also know, or at least think, that this can't be the whole story since all kinds of treatments that operate through psychological mechanisms are not thereby placebos. What, then, is the psychological mechanism at play in certain treatments that make those treatments placebos? No one is quite sure how the placebo effect is generated, but here are three fairly standard accounts (the third is specifically concerned with placebo as analgesia):

What all of these explanations [just discussed in the article] have in common . . . is the element of expectation, the promise of help on the way that can only be imparted by another human being.<sup>18</sup>

Research has confirmed that a fake treatment, made from an inactive substance like sugar, distilled water, or saline solution, can have a 'placebo effect' — that is, the sham medication can sometimes improve a patient's condition simply because the person has the expectation that it will be helpful.<sup>19</sup>

We propose that two general factors mediate placebo analgesia: (1) *a desire or need for relief of pain* and (2) *an expectation that a given procedure or agent will relieve the pain*.<sup>20</sup>

All three articles identify 'expectation' as central to the efficacy of a placebo: it is only because the patient *expects* to get better that the treatment is able to work. Of course, it does not follow from the fact that people usually take expectation to be central to the causal efficacy of placebos that in fact it is; perhaps our intuitions on this matter are faulty. Nonetheless, in what follows I give the appeal to expectation, as we might call it, the benefit of the doubt and ask: if expectation is the central factor in understanding placebos, what can it tell us about the nature of placebos and the ethics of administering them in a clinical setting? One indication that the appeal to expectation is not misplaced is, as I shall demonstrate below,<sup>21</sup> that the conception of placebo it gives rise to does a good job explaining most people's thought that there is *something* fishy in prescribing placebos in a clinical setting. Placing the concept of expectation at the heart of our understanding of placebos opens the door to a nice explanation of this thought.

The idea that placebos operate through expectation separates placebo treatments from other psychologically-based treatments. To take but one example: talking therapies

clearly operate through cognitive mechanisms. The patient improves by talking about and coming to understand various aspects of his life. But we don't think in this case that the patient's *expectation* that he will improve is the *mechanism* of improvement. Indeed, we need not attribute this kind of expectation to the patient at all: someone might find therapy helpful in spite of his expectations to the contrary. It is easy to imagine someone saying, 'I didn't expect psychotherapy to work at all, but it has worked wonders'. Of course, this imagined scenario is by no means decisive. It is possible for someone to have a 'hedged' expectation where the person does not, all things considered, expect a particular outcome, but nonetheless entertains the thought that it might possibly happen. In doing so, the person might manifest behaviours, or have dispositions and patterns of thought similar to someone who genuinely expects a certain outcome. As such, someone who does not expect therapy to work in the full-blooded sense, might nonetheless experience the placebo effect through hedged expectation. Perhaps something like this is the best explanation of what is going on with my (admittedly underdescribed) psychotherapy patient. The point is simply that it need not be. For I all I have said so far, various forms of psychotherapy need not automatically count as placebo treatments. For it is not necessarily true that the cognitive mechanisms that operate through (essentially) depends on the patient's expectation that he will get better.

So a placebo operates through a cognitive mechanism that relies on the patient's expectation that he will improve. How does this expectation work? I am not interested in how expecting to get better can cause psycho-physiological improvement. Nor am I interested in what we might call the anthropology of what must be in place in a clinical setting to get the right kind of expectation in play — although this is a fascinating topic.<sup>22</sup> Instead, I am interested in what the nature of expectation, as a particular intentional attitude, reveals about the state of mind of the person receiving the placebo. If you are like me, you probably have the intuition that there is something strange in this. But what is it?

The first thing to note is that there is nothing strange, in general, with the idea that my having a certain intentional attitude is partly responsible for bringing about some state of affairs. Moreover, that fact that some state of affairs came about as a result of my intentional attitude can be transparent to me. Such is the case with *intending* as can be illustrated by way of a simple example: Suppose I tell you that we will be having duck soup for dinner tonight. You might wonder how I know this. Well, one way I could know it is because *I* am making dinner and I *intend* to make duck soup. My claim that we will be having duck soup tonight is not a *prediction*, as it would be if I were asked to guess what someone else would be making for dinner, but the expression of an *intention*. And it is because I intend to make duck soup that I can claim to know that we will be eating it later tonight. In other words, I can see my intention as part of the mechanism, part of the *reason*, why some state of affairs, in this case eating duck soup for dinner, comes about. I can cite my own intention in an explanation of how it is we ended up eating duck soup for dinner. So there is in general nothing strange in my understanding my intentional attitudes as the mechanism through which changes in me, or the world, occur.

Perhaps the strangeness, then, lies in the particular intentional attitude implicated in the placebo effect, namely *expectation*. Isn't it strange to bring something about simply by expecting that it will happen? Not necessarily. For whenever I sincerely intend to do something, I expect that it will happen.<sup>23</sup> And, as we have just seen, there is nothing

mysterious about my intending X being the causal, cognitive mechanism through which X comes about. But the thing to notice here is that the expectation is parasitic on the intention, and it is in virtue of my intention that, under certain circumstances, I can bring something about when I expect that it will happen. In other words, the intention, and the not expectation, is the mechanism that brings X about. *The expectation is epiphenomenal.* And so cases where people intend to, and so expect, X and bring X about because they intend it are not examples of the placebo effect at work. This is important, because it allows us to demarcate another class of cognitive treatments as non-placebos. Consider, for example, someone who is able to lower her blood pressure through cognitive relaxation techniques. Of course, this person expects that her blood pressure will drop in virtue of her state of mind, but she expects it because she intends it, which is just to say that she plans to take action that will result in her blood pressure dropping. Expectation is (necessarily) present, but it is not the mechanism of the cure.

But in a placebo treatment it *is* the mechanism of the cure: the cure relies on the patient's expectation that she will improve. And that is strange. Why? Because one cannot treat one's own expectation that X will occur as a reason for expecting X to occur. Put another way: one can only expect something to happen if one believes one has independent reasons — reasons that exist apart from one's own expectation — for expecting the thing to happen. Indeed, I *justify* my expectation in terms of those other reasons. Those reasons might have to do with my other intentional attitudes (I expect to eat duck soup for dinner because I intend to make it), or they might have to do with facts that have nothing to do with me (I expect the Canadiens to win the Stanley Cup because they have a good team this year). But whatever they are, my reasons for expecting anything must reach beyond the fact that I expect it. So, were someone to ask, 'Why are you expecting duck soup for dinner?' I cannot answer, 'Because I *expect* duck soup for dinner'. In other words, and this is the key point, *I cannot take my expectation as the mechanism that causes whatever it is I expect.* This is not an empirical point, but a conceptual one about the nature of expectation. We can put the point like this: *Part of what is involved in sincerely expecting X is believing that one's expectation is causally inert with regards to the question of whether X will come about.* To expect X is necessarily to see one's expectation as epiphenomenal with respect to X occurring.

When we put things like this, the strangeness of the placebo effect becomes clear: the placebo effect just is the effect that is *caused* by the patient's expectation that she will get better. But because of the nature of expectation, the patient cannot understand that her own expectation is the causal mechanism without, at the very same time, abandoning the expectation since part of what it is to expect something (rationally or otherwise) is to believe that one's expectation is causally inert with regards to the question of whether what one expect to happen will happen. Insofar as the patient expects to get better, he must believe there are independent reasons that support his expectation. But in the case of a placebo it is really nothing more than his own expectation that is the means of the cure. And so in order for the placebo to work the patient must have a false belief about what justifies his expectation (even if it is only a negative belief to the effect that 'However the cure works, its causal efficacy does not depend on my expectation that it will work').<sup>24</sup> He cannot come to understand the reason that warrants his expectation that he will get better, namely that he expects to get better. The reason that ultimately justifies his expectation are necessarily opaque to him since to so much as expect something

involves believing that there is something other than the fact that one expects X that explains why one expects X (even if one cannot say anything about what that something else is).

The upshot is that the patient cannot, in principle, come to understand the role his cognitive attitude (of expectation) plays in the cure without thereby rendering the cure ineffective (i.e. no cure at all). Notice that if this is right, then we have an explanation for the empirical fact that placebos only work if the patient does not know she is taking one.<sup>25</sup> The empirical fact is explained by the conceptual one about the logical structure of expectation.

### 3. The Ethical Issue

#### 3.1. *Answering the Charge of Deception I*

If the reasons that warrant a placebo-receiving patient's expectation that she will get better are necessarily opaque to her, then the key ethical issue surrounding placebo treatment in a clinical setting becomes clear: since the placebo effect necessarily involves a lack of transparency, administering it necessarily involves deception. This is not a novel thought. But the precise nature of the deception has not been appreciated, as standard responses to the charge of deception reveal.

Consider the following response to the charge of deception:

The ethical problem most frequently raised regarding the administration of the placebo is that the doctor is deceiving the patient. The patient wants an effective treatment; instead he receives a placebo. On these grounds, some have maintained that placebo treatment will always be unethical, a violation of the patient's right to be honestly and fully informed about treatment.

Examined carefully, this point may be greatly overstated. The assumption upon which this issue rides is that only through pharmacology or similarly respectable and rational procedures can the doctor aid the patient. This has never been true, and even in an age of evidence based medicine remains untrue. [. . .] *The placebo is a deception only for those who would reduce treatment to a purely biomedical pursuit.* The discomfort for today's physician in using the placebo . . . will often reflect less ethical misgivings than an outmoded Cartesian prejudice that bodily illness cannot be tended to by emotional means.<sup>26</sup> [Emphasis added.]

The authors of this paper seem to be saddling their opponents with two conflicting views. First, they sum up the charge of deception as follows: 'the doctor is deceiving the patient. The patient wants effective treatment; instead he receives a placebo'. The authors here are implicitly committing their opponents to the view that placebos are ineffective, don't produce real results, are just shams. But their response reveals that they take their opponents to have a different understanding of the objection, namely that while placebos are effective (and so the patient gets what he wants), they are unrespectable or irrational because they do not operate solely through biomedical, or as I have been putting it, non-cognitive, causal mechanisms. And they dismiss this worry as nothing more than a lingering Cartesian prejudice (whatever that might mean).

But neither of these understandings of the charge that placebo treatment is deceptive hits the mark. With regards to the first understanding, I have already shown that there is no compelling sense in which placebos should be defined as ‘inactive’ or ‘ineffective’ since there is tremendous evidence to the contrary. So when a patient wants an effective treatment and the doctor gives him a placebo that is effective, the patient is not being deceived in virtue of being given something ineffective, because he is not, after all, getting something ineffective.

The authors’ second understanding of the charge of deception also misses the mark. The nature of the deception that I have identified as inherent in placebo treatment does not rest on a distinction between treatments that operate only through biomedical mechanisms and those that do not: as I have argued, there are all kinds of treatments that are effective only through cognitive causal mechanisms that are not, thereby, placebos. As such, identifying certain kinds of treatments as placebos, and so unethical, does not depend on the so-called Cartesian prejudice that ‘bodily illness cannot be tended to by emotional means’, since my analysis allows that bodily illness *can* ‘be tendered to by emotional means’ — means which are not placebos. Moreover, in a treatment like psychotherapy, where the cure is effected through cognitive, causal mechanisms, there is no expectation on the patient’s part that the cure will be come about through purely biomedical means. Where, then, is the deception?

What the authors fail to see is that the placebo/non-placebo distinction does not rest on the distinction between non-cognitive, causal mechanisms and cognitive, causal mechanisms of cure, but on *a particular kind of cognitive, causal mechanism of cure versus every other kind of mechanism of cure (cognitive or non-cognitive)*. And, as I have shown, the particular kind of cognitive, causal mechanism of cure involved in placebo treatments, depending as it does on the intentional attitude of expectation, necessarily involves deception.

### 3.2. *Answering the Charge of Deception II*

Another common response to the charge of deception recognizes that there is something less than truthful about placebo treatment but denies that this is the same as deceiving the patient. Consider the following two suggestions for how to be honest with a patient to whom one gives a placebo:

The way that the physician reports the nature of the placebo she is offering is important here, as she tries to maximise the therapeutic effect without being dishonest with the patient. A possible statement might take the form of: ‘I would like to offer you a pill which I believe can help lessen your suffering. I do not know exactly how it works. I have other pills to offer whose mechanism is clearer, but I am not sure that they will work better for you, and they may also entail more serious side effects’. In this manner, the physician is being open and honest with the patient.<sup>27</sup>

[Dr Walter A. Brown] imagines the doctor saying something like this [to a patient he wants to prescribe a placebo for]: ‘Mrs Jones, the type of depression you have has been treated in the past with either an antidepressant medicine or psychotherapy, one of the talking therapies. These two treatments are still widely used and are options for you. There is a third kind of treatment, less expensive

for you and less likely to cause side effects, which also helps many people with your condition. This treatment involves taking one of these pills twice a day and coming to our office every two weeks to let us know how you're doing. These pills do not contain any drug. We don't know exactly how they work; they may trigger or stimulate the body's own healing processes. We do know that your chances of improving with this treatment are quite good. If after six weeks of this treatment you're not feeling better we can try one of the other treatments.<sup>28</sup>

The thought here is that since the doctor does not tell the patient anything false, the doctor is not deceiving the patient. And to further flesh out this line of thought, the doctors might point out that this is just the explanation they might give of a non-placebo treatment that is not well understood. In such a case, there is no thought that the patient is being deceived. And so, the reasoning might go, there is no reason to think that exactly the same explanation is deceptive in the case of describing a placebo.

Furthermore, we cannot complain that the explanation is incomplete and, as such, unable to form the basis for the patient's consent. Or, if we do, then we must be prepared to level the complaint against most, if not all, explanations that doctors and nurses give when explaining treatments. In the very least, such explanations often exclude an account of the causal mechanism through which the treatment works for the simple reason that most patients cannot understand the explanation. More often than not, a treatment will be described in terms of its effects — its risks and benefits — and this is just what the doctors above propose doing with placebo treatments. On the face of it, the kind of explanation offered above is just another instance of the kinds of explanations that are unproblematically provided to patients all the time.

There is something to this line of thought: if nothing else, it cautions us from criticizing the proposed explanations on the grounds that they are incomplete and so unable to form the basis for a patient's consent. But the conclusion that the kind of explanation offered above is just another instance of the kind of explanation offered for non-placebos is wrong. The reason emerges when we consider the unique way the incompleteness of the explanation functions in placebo cases.

The first thing to note is that the sort of explanation of the placebo treatment that the doctors suggest is not simply incomplete but *necessarily* incomplete. The same is not true of non-placebo treatments: there is no principled reason why patients could not be told the intricacies of the causal mechanism through which a non-placebo treatment works. Of course, there are all kinds of practical reasons why patients are rarely, if ever, so informed — the details of the treatment might elude them, or make them squeamish or nervous. Perhaps the patient insists that they do not want to know the details and demand that the doctor simply 'do what works'. But, and this is the crucial point, there is nothing in the nature of the treatment itself that *demand*s that the patient receive less than complete information. This means that while actual practices of getting informed consent from patients for non-placebo treatment might fall away from the ideal — i.e. complete information about the nature of the procedure — they need not: the ideal of informed consent is not necessarily at odds with the method of treatment. The same is not true in the case of placebo treatments: the nature of the cognitive causal mechanism through which the placebo is effective precludes the possibility of the ideal of informed consent being met.

The relevance of this point is not immediately clear, for we might wonder whether there's really an ethical difference between an incomplete explanation that, for practical reasons, falls away from the ideal and an incomplete explanation that, conceptually, must always fall away from the ideal. I won't answer that point here. But the fact that a certain kind of treatment is *necessarily* at odds with an enshrined principle of clinical ethics should give us pause about prescribing it.

But the fact that an explanation to a patient of how a placebo works must be incomplete does not yet show that prescribing a placebo is deceptive. Nonetheless, understanding why the explanation is incomplete reveals that it is deceptive. For in offering an essentially incomplete explanation, the doctor actually aims to induce a false belief in the patient about the treatment. Both of the suggested explanations about placebo treatments offered above give the patient some expectation that he will improve with the treatment. For reasons we have seen, that expectation necessarily involves the belief that the expectation is causally inert with respect to the effectiveness of the treatment: this is part of what it is to expect something. Thus, insofar as the doctor aims to induce expectation in the patient, she aims to induce the belief (in the patient) that the cure is effected through some process other than the patient's expectation. Indeed, it is crucial to the inculcation of the expectation that the patient be given some reason to expect the treatment will work since, as we have seen, expectation demands a justification other than itself. We can see this strategy at work particularly clearly in Brown's imagined explanation to Mrs Jones of her placebo treatment: he tells her that the treatment contains no drug. But then he immediately adds that the treatment might function by 'trigger[ing] or stimulat[ing] the body's own healing processes'. Of course, there's a sense in which this is true: the body heals itself through the cognitive mechanism of expectation. But the explanation suggests that the process is non-cognitive: the treatment will simply cause (stimulate, trigger) the body to heal itself regardless of what the patient expects.

The point here is not just that the patient has a false belief about her treatment — surely a common occurrence. And it is not necessarily the healthcare team's responsibility to always correct these false beliefs (though in some cases it surely is). What is crucially different in the case of a patient who is receiving a placebo is that the false belief is *induced* by the healthcare team and then *used* as a part of the treatment. And inducing a false belief in order to manipulate another person — even for that person's betterment — is surely deceptive. So, even though doctors and nurses would not be lying to their patients if they explained a placebo treatment in the way Brown or the others suggest, they will still be deceiving them. And this isn't a surprise, since it is perfectly possible to deceive people without lying to them.<sup>29</sup>

Notice too that clarifying the way in which placebos are essentially deceptive explains the sense in which they are 'shams'. What makes the treatment a sham is not that it is 'inactive' or has no physiological properties — we've already seen that that is not a helpful way to think about it — but that it essentially involves deception. It is a sham in essentially and necessarily purporting to be something that it is not. Often it is purporting to be a non-cognitive, causal cure. But it need not be. It could purport to be a cognitive, causal cure, like psychotherapy, which does not rely for its efficacy on the patient's expectation. But it cannot purport to be what it is: a cognitive, causal cure that works by inducing in the patient the expectation that he will improve.

#### 4. Conclusion

If placebo treatments are necessarily deceptive we might conclude that they are impermissible in a clinical setting. But that does not follow. Someone might grant that placebo treatment is necessarily deceptive, but think that the costs of deception are outweighed by the gains, such as relieving someone's suffering. Consider the views of placebo researcher Michael Jospe as recounted in an article for the magazine *FDA Consumer*:

Some circumstances, [says Jospe,] justify this kind of benevolent deception — like when a patient insists on a medicine that is unnecessary and carries needless risks.

'You've got to be there on the oncology ward', Jospe says, 'and see how suffering people get so demanding of drugs that might be extremely harmful to them. If you look at sugar pills in the broader context of a supportive doctor-patient relationship rather than just as ripping off the patient, you may come to a different conclusion' about the ethics of placebos.<sup>30</sup>

Even here, there is a misunderstanding about what the real worry surrounding placebos is: the considerations I've raised against placebo treatment have nothing to do with 'ripping off the patient'. Indeed, I've granted that placebos can be effective at treating illness and so offered benevolently. But Jospe's main point is clear enough: he does not deny that there is something deceptive about giving a placebo, but he simply thinks that such deception is justified in certain cases.

Nothing I have said responds to this kind of view, which acknowledges the costs of deception that come with placebo treatments. But it is worth noticing the following two points. First, even if we do think placebo treatment is justifiable, it cannot become the standard of care unless the standard of care is totally unknown to patients (otherwise, it would no longer be effective). Second, and more important, an argument of the kind offered by Jospe must ultimately engage with the question of how the ideals that are usually taken to inform the ethics of clinical care — beneficence, non-maleficence, autonomy and justice — interact. In particular, an argument in favour of placebo treatment must argue that beneficence can at least sometimes override autonomy since placebo treatments essentially run counter to the ideal of informed consent, which is central to the ideal of patient autonomy. In offering such an argument, a proponent of placebo treatment would effectively be suggesting that autonomy not be the master value, or trump consideration, that it currently is in clinical practice.<sup>31</sup> And so a complete discussion of the place of placebo treatments in clinical practice will, in effect, be a discussion about the place of patient autonomy in medicine.

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## NOTES

- 1 For discussion of this topic see R. J. Connelly, 'Deception and the placebo effect', *IRB: Ethics and Human Research* 9 (1987): 5–7 and A. Cahana & S. Romagnoli, 'Not all placebos are the same: A debate on the ethics of placebo use in clinical trials versus clinical practice', *Journal of Anesthesia* 21 (2007): 102–105 and A.K. Shapiro & E. Shapiro, *The Powerful Placebo: From Ancient Priest to Modern Physician* (Baltimore, MD: The Johns Hopkins University Press, 1997).
- 2 F. Miller & S. Horng, 'Is placebo surgery unethical?', *New England Journal of Medicine* 347 (2002), 137–9.
- 3 These are, of course, very different ideas, as what a patient takes to be in her best interests may well not actually be in her best interests. But I want to put that issue aside.
- 4 For an account of this kind of motivation in a clinical setting see, E. A. Fox, 'Confronting the use of placebos for pain', *The American Journal of Nursing* 94 (1994): 42–46.
- 5 For a dissenting opinion see A. Hrobjartsson & P. C. Gotzsche, 'Is the placebo powerless? An analysis of clinical trials comparing placebo treatment with no treatment', *New England Journal of Medicine* 344 (2001): 1594–1602. For a response to this paper, see F. G. Miller & D. L. Rosenstein, 'The nature and power of the placebo effect', *Journal of Clinical Epidemiology* 59 (2006): 331–335.
- 6 See Section 3.
- 7 Connelly op. cit., p. 5.
- 8 H. Brody, 'Placebo' in Warren T. Reich (ed.) *Encyclopedia of Bioethics* (London: Simon & Schuster MacMillan, 1995) pp. 1951–1953.
- 9 National Institutes of Health, The Placebo Effect in Clinical Practice, 2001, <http://grants.nih.gov/grants/guide/rfa-files/RFA-AT-02-001.html>
- 10 In what follows, I drop the 'pharmacological' side of the equation. I suspect that what I go on to say is as true of pharmacological properties and changes as it is of physiological properties and changes, but I don't know enough to be sure.
- 11 For many more examples see D. Jopling, *Talking Cures and Placebo Effects* (Oxford: Oxford University Press, 2008).
- 12 Both of these cases are recounted in P. D. Wall, 'The placebo effect: An unpopular topic', *Pain* 51 (1992): 1–3. The first case was originally reported in L. A. Cobb, D. H. Dillard, K. A. Merendino, R. A. Bruce & G. I. Thomas, 'An evaluation of internal mammary artery ligation by double-blind technic', *New England Journal of Medicine* 20 (1959): 1115–1118. The second case was originally reported in I. Hashish, W. Harvey & C. Feinman, 'Reduction of postoperative pain and swelling by ultrasound: A placebo effect', *Pain* 83 (1988): 303–311.
- 13 It's worth noting that this general idea was put forward, in a different context, by William James over a hundred years ago in *The Varieties of Religious Experience* to argue against what he called 'medical materialism', the view that all religious experience can be explained away by psycho-physiological causes. James observes:
 

Scientific theories are organically conditioned just as much as religious emotions are; and if we only knew the facts intimately enough, we should doubtless see 'the liver' determining the dicta of the sturdy atheist as decisively as it does those of the Methodist under conviction anxious about his soul. [. . . ] *So of all our raptures and our dryness, our longings and pantings, our questions and beliefs. They are equally organically founded, be they religious or of non-religious content.* [Emphasis added] W. James, *The Varieties of Religious Experience* (New York: Penguin Books, 1985), p. 14.
- 14 For an interesting discussion of the history of defining placebos as inert see Shapiro & Shapiro op. cit., pp. 33–36. They conclude that, 'Limiting the definitions of placebo to inert medication is historically inaccurate, not in keeping with modern usage, and irrelevant, arbitrary, and heuristically useless'.

- 15 M. Talbot, 'The placebo prescription', *The New York Times Magazine* 9 (2000), 34–39.
- 16 P. Lichtenberg, U. Nitzan & U. Heresco-Levy, 'The ethics of the placebo in clinical practice', *Journal of Medical Ethics* 30 (2004): 551–554.
- 17 Although nothing in my argument turns on my denying that they are placebos: it may well turn out that many of them are. It is, I take it, largely an empirical matter whether various forms of psychotherapy are placebos. I discuss this briefly in the next section. On the relationship between 'talking therapies' and placebos see Joplin *op. cit.*, *passim*.
- 18 Talbot *op. cit.*
- 19 T. Nordenberg, 'The healing power of placebos', *FDA Consumer Magazine* 34 (US Government Printing Office, 2000).
- 20 D. D. Price & H. L. Fields, 'The contribution of desire and expectation to placebo analgesia: Implications for new research strategies' in A. Harrington (ed.) *The Placebo Effect* (Cambridge, MA: Harvard University Press, 1997), 117–137.
- 21 See Section 3.
- 22 I take Daniel Moerman's *Meaning, Medicine, and the 'Placebo Effect'* to be engaged in this project. In other words, I see Moerman's conception of the placebo effect in terms of a meaning effect that is generated by what we might call the culture — broadly construed — of clinical encounter as not only consistent with my view, but supportive of it inasmuch as Moerman's task is to explain what factors in a clinical encounter tend to generate the kind of expectation that often leads to healing. See D. Moerman, *Meaning, Medicine, and the 'Placebo Effect'* (New York: Cambridge University Press, 2002).
- 23 What if I intend to do something very, very difficult, something with a high chance of failure? There's no problem if I don't know there's a high chance of failure or if I am cocky and think that despite the odds, I'm going to succeed. But if I know I am unlikely to succeed, surely I cannot sincerely intend to make it happen. At best I can intend to try to make it happen.
- 24 This is not to say that the patient cannot also have some true beliefs about what justifies his expectation. A patient might know of a study showing that the treatment he is receiving is 70% effective, but not know that it is a placebo treatment. Here the patient reasonably expects the treatment to work, which is to say he has access to a reason that justifies his belief that the treatment will work. Nonetheless, he does not have access to the reason that, we might say, ultimately sanctions his expectation (in as much as it explains why the treatment is effective 70% of the time), viz. that his own expectation is the mechanism of the cure. Thanks to Charles Weijer for raising this point.  

Must the patient have a false belief as I have claimed? Suppose the patient says the following to herself: 'Knowing what I know about psychology, I know that a strong expectation of improvement in health typically produces improvement in health; if I have such an expectation, that will immediately justify my expectation. And I do have a strong expectation, which I now know is justified'. In this case, the patient appears to have no false belief: she faces the reality, as it were, of what is likely to improve her health head-on. That is true, but the situation we are imagining assumes what I deny, viz. that the patient can sensibly say to herself, 'If I have such an expectation, that will immediately justify my expectation'. If I am right, it is in the nature of expectation that one cannot sincerely say this to oneself since having an expectation involves the belief that the expectation cannot 'immediately justify' itself. Perhaps this is true in general, but not in the case of a placebo treatments? I suppose that is possible, but I don't see why we should think this likely: my account turns on the nature of expectation itself, which includes expectations about future health in the light of various treatments. It would be odd indeed if the general point didn't apply in the specific context of expectations about future health. We might ask: what is it about the *content* of the expectation in these contexts that would make it reasonable to think health-related expectations (and only health-related expectations) can be self-justifying? My thanks to an anonymous referee for this journal for pushing me on this point.
- 25 There is some evidence that this is not right. See L. C. Park & L. Covi, 'Non-blind placebo trial. An exploration of neurotic patients' responses to placebo when its inert content is disclosed', *Archives of General Psychiatry* 12 (1965): 336–345. But if I am right then it can't be the case that in these studies the patient really understands what makes the treatment a placebo.
- 26 Lichtenberg *et al. op. cit.*
- 27 Lichtenberg *et al. op. cit.*
- 28 Talbot *op. cit.*
- 29 The above authors seem to understand the demand that one be honest with one's patients as nothing more than the demand that one not lie to one's patients. But that is an overly narrow view of what is involved in

being honest. For a lengthy discussion on this point see B. A. O. Williams, *Truth and truthfulness: an essay in genealogy* (Princeton, NJ: Princeton University Press, 2002), ch. 5.

30 Nordenberg op. cit.

31 For an interesting discussion of the rise of the concept of autonomy in bioethics see, J. E. Smith, 'The pre-eminence of autonomy in bioethics', in D. S. Oderberg & J. A. Laing (eds) *Human Lives: Critical Essays on Consequentialist Bioethics* (New York: St. Martin's Press, 1997), pp. 182–195.