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article

The Ethical Placebo

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In this paper, I challenge the view that the deceptive nature of placebo treatments creates an insurmountable ethical barrier to their use. I agree that placebo treatments are deceptive, and argue that deception is required to maximize the benefit of placebo treatments, but explain that the usual objections against deceiving patients do not apply in this special case, since placebo deception can be unlike other forms of clinical deception. I explain that clinical deception should only be considered paternalistic or coercive when it fails to serve the stated interests of the patient.

Aside from the claim that placebos are coercive, there is a range of objections to the use of placebos in clinical practice in the literature. I show how these remaining ethical objections pose significant, but not insurmountable moral barriers to the clinical use of placebo. By using placebos within a set of coherent ethical constraints, it is possible to prescribe them in a way that maximizes patient benefit while preserving their autonomy and preventing them from being abused or coerced. Although these constraints turn out to be extensive, I demonstrate that one very common case—depression—makes it feasible to use placebo treatments within appropriate moral boundaries.

Finally, I explain how doctors should deal with a patient's discovery of the nature of their placebo treatment, and I offer an argument in defence of the practice of charging patients for placebo treatment.

If doctors are aware of the various constraints on their use, placebo medications can form a useful treatment option for the occasional circumstances in which they can be beneficially and ethically administered.

Introduction

One of the oldest debates in medical ethics concerns the deceptive prescription of pharmacologically inert medicines, or 'placebos', to patients in the clinic. Doctors have long understood that the suffering of patients could be ameliorated by sham treatments, but the deceptive nature of these treatments—at least on its face—contravenes the strong prohibition against the deception of patients contained in the norms, guidelines and laws that constitute modern medical ethics.

In this paper I will seek to resolve the ethical debate over clinical placebo use by showing that it involves a special case of deception, which is not subject to the same ethical objections as other forms of clinical deception. There remain a number of specific objections to placebo use which do not relate to the general impermissibility of deception, but I will show that these objections ought to *limit* our use of placebos in certain ways, but not *prohibit* it entirely.

These arguments require that we first agree that placebos are both efficacious and deceptive, and that the deception is required to maximize their efficacy, so I will begin by addressing these issues.

Controversy over the relative efficacy of placebo therapies

In addition to the ethical controversy, there is an enduring scientific controversy over whether placebos are effective as a clinical treatment, and whether or not they can be made to work when the patient knows he is getting a placebo. For the sake of brevity, I am going to begin by assuming that placebos are effective at least for relief of symptoms, that they are always beneficial in the clinic†, and that their effectiveness depends, at least in part, on the patient being unaware that he is receiving a placebo.

Whether or not these presumptions are correct is largely an empirical question. In a previous paper, I reviewed some of the available data (Foddy, 2009). Evidence from sources such as Irving Kirsch's study presented in 2010, or Bingel's recent fMRI study, give us reason to believe that clinical placebos can be both effective and beneficial (Kirsch, 2010; Bingel et al., 2011). Yet there is very little in the way of direct evidence concerning the usefulness of placebo in the clinic, or concerning the effect of deception on the magnitude of the placebo effect. Why is this?

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† Harmful 'nocebo' effects are sometimes observed in a research setting, where patients have no positive expectation that the treatment will work. As I have argued elsewhere, these effects are likely very rare in a clinical setting.

One reason is that when placebos are given in a research context, it is almost always because researchers need to *control for* the placebo effect—they are not trying to elicit or maximize it. They tell their subjects that they will receive either an active medication or an entirely inert one, and as Kirsch suggests, patients can frequently tell whether or not they have received a placebo because only the active medication produces side-effects (Kirsch, 2010). For these reasons, the magnitude of the placebo effect measured in clinical trials is certainly underestimated, though to what degree it is impossible to guess.

There are very few empirical studies of the clinical use of 'deceptive' placebo, wherein a doctor prescribes a placebo without telling the patient that he may receive an inert substance. The reason for this is twofold: first, the deception of research subjects is prohibited in both medical research by the doctrine of informed consent.(Wear, 1998) Research subjects can be deceived, but they must give prior consent to any deception which is made in the course of the research. Second, the use of deceptive placebos is explicitly prohibited in the clinic, rendering the results of such studies moot (AMA, 2007). Since deceptive placebo use cannot be studied, the difference between deceptive and non-deceptive placebo use cannot be measured within the ethical guidelines governing modern medical research.

Aside from the difficult empirical questions of whether placebos are effective and whether deception is required, however, there is a separate philosophical question concerning whether and when a doctor may prescribe a deceptive, albeit beneficial and efficacious placebo in the clinic. It is this question with which I am concerned in this paper.

Are placebos indeed deceptive?

In using a placebo to treat a patient, the doctor's primary aim is to make her patient believe something that she believes to be true: that he will feel better. It is worth examining what is usually assumed—that the prescription of placebo is deceptive. Consider the following placebo vignette:

> The patient, John, has a form of viral conjunctivitis, for which no treatment is available or required. It causes pinkness in his eyes and an itching, uncomfortable sensation. His symptoms, though embarrassing and uncomfortable, will disappear after a few days. Susan, his doctor, believes that her patient's felt discomfort could be alleviated by a placebo. She hands him a small unlabeled bottle of eyedrops, which she knows to be saline solution, and says, "Take these twice a day. They will not alleviate the pinkness of your eyes, but they will reduce the uncomfortable sensation while your immune system takes care of the virus." Susan believes that what she is saying is true: by means of psychological association (the placebo effect), the drops will reduce John's felt discomfort. But this effect demands that John strongly associates the drops with medicines he has received in the past. If John believes that the drops operate through a psychological rather than chemical mechanism, the effect will be much weaker. So, in order that the treatment can work, Susan simply omits to tell John *how* she thinks the eye drops will work, and he does not ask for more information, assuming that any medical explanation will be beyond his level of understanding.

To use the formulation of Igor Primoratz, when we lie we make 'a statement believed to be false, with the intention of getting another to accept it as true.' (Primoratz, 1984). The only overt statement which Susan makes in this case is a statement she believes to be true. She sincerely predicts that taking the eye drops twice a day will reduce the discomfort in John's eyes. She has not told a lie.

But Susan has, in telling the truth, led John to hold two true beliefs and one false belief. He comes to believe correctly that he will feel better, and that taking the drops will make him feel better, but he also now holds the false belief that the eye drops work through a similar mechanism to other eye drops he has taken. Since she deliberately leads him into this false belief, Susan has *deceived* John.

Is deception necessary in placebo prescription?

Patients seek out doctors expecting to have their diseases cured, and when that cannot be done, they expect to have their unwanted symptoms alleviated. Sometimes, the only way that the symptoms can be treated is through the use of the placebo effect (Foddy, 2009). And in order to harness the placebo effect, the patient needs to believe, at some deep level, that the treatment will make him feel better.

At one level, it is thoroughly rational to believe that taking a placebo will make us feel better. Patients ought to believe that they will feel better, since their goal—the alleviation of their symptoms—will be met, to some extent, just so long as they believe it will be met.

Unfortunately, as Gibbard points out, "Beliefs seem like prime examples of what we can appraise as rational or irrational, but beliefs, like emotions, cannot be had or cast off at will. We may be able to "make believe" at will, but that is not the same as really believing at will" (Gibbard, 1990. p.38). I might believe, on reflection, that I will feel better just so long as I believe I will feel better. But I cannot just make believe that I will feel better, and I cannot simply will myself into believing what I realize to be true.

In any case, the placebo effect does not seem to harness a high-level, reflective expectation that one will feel better. Instead, it harnesses conditioned associations between medicines and medical benefits (Benedetti, 2006; Colloca & Benedetti, 2006). Because of this, it would not be enough to believe that I will get better through the placebo effect, even if I could deliberately form such a belief. I need to believe, sincerely, that what I am getting is similar to the treatments that have made me feel better in the past.

Clearly it is impossible to form a false belief such as this by oneself. An accomplice is needed. The accomplice must recognize and respect my goal—that is, to feel better—but I can never explicitly ask the accomplice to deceive me, or else I will not form the right kind of false belief. The relationship between doctor and patient is the exact kind of structure which can make possible this type of epistemic sleight-of-hand; since the doctor (or some other doctor) has given me efficacious therapies in the past, I will associate whatever treatment she gives me with past pharmacological benefits. When a doctor leads a patient into holding a beneficial false belief in this way, that is (by definition) deception.

It is possible that we can harness the *unconscious* association between pills and benefits that many people have formed. Perhaps if I give myself a placebo, or if a doctor gives me a placebo openly, letting me know that she expects to elicit a placebo effect, it will not matter that I do not consciously expect a pharmacological effect. Perhaps my unconscious expectation of an effect will be enough to produce a benefit. This suggestion is made by the American Medical Association in its policy which prohibits deceptive placebo use, and it was explored in one study by Park & Covi in 1965, which is now thought to be flawed (AMA, 2007; Park & Covi, 1965; Klein, 1994).

A recent paper by Kaptchuk et al. provides newer evidence for the effectiveness of such 'open' or 'nonblind' placebos compared to the absence of treatment, but it fails to compare the effectiveness of the open placebo to the effectiveness of deceptive placebo (Kaptchuk et al. 2010). In fact, other than Park & Covi's flawed study, we have no evidence suggesting that such open placebos work anything like as well as deceptive placebos, and no evidence is likely to be forthcoming since it would require that researchers deceive their control group.

If further evidence does appear, it may turn out that open placebos can be as effective as deceptive placebo—that the placebo effect can be of full benefit even when a patient consciously believes there is no commonality between the placebo and their past, pharmacological treatments. Until then, given the paucity of evidence to that effect, we should assume what is more plausible: either that open placebos do not work, or that their effect is much more limited than the effect of deceptive placebo. We should assume that in order for a placebo treatment to provide the maximum benefit, the patient needs to *falsely* believe that he will get better through the action of some pharmacological agent.

While I cannot offer empirical proof that deception is required to maximize the beneficial placebo effect, there is a kind of categorical argument which is often used to support the claim that deception is *not* required in the use of placebos. This argument suggests that deception is not required because the placebo effect can be utilized even without deceptively giving an inert treatment. Part of the benefit of regular, non-deceptive therapies is that they employ the placebo effect, as Dan Moerman suggests in this issue (Moerman, 2011). The placebo effect is also engaged in the course of a clinical consultation, when a doctor engages with the patient and shows genuine concern. This effect can be maximized by maximizing the patient's unconscious expectation of benefit when prescribing an active medication, either by verbal means or by using nonverbal cues (Moerman, 2011). Deception is not required in order to harness the placebo effect in these ways.

But we should be careful about how far we stretch this point; for one thing, there are many cases in which no efficacious medicine can be given (more on this below). In these cases, doctors may be tempted to give ineffective but pharmacologically active medications in the hope that this avoids deception while eliciting a placebo response (Kolber, 2008). Susan might have given John aspirin, for example, thinking that she could tell him he was receiving a medicine without deceiving him. But this would be a mistake. Even though aspirin is a pharmacologically active medicine, if Susan believes it will have no beneficial pharmacological effect on John's ailment, it is a placebo, and it is a deceptive placebo if she leads him to falsely believe that he is getting a therapy with a significant pharmacological action. If the

doctor wants to harness the placebo effect using pills or eye drops when it is not possible to give a significantly effective treatment, deception will always be necessary.

On a dogmatic reading of the rule against deceiving patients, this makes the effective use of placebos in the clinic an impossibility. But, I will argue, placebos represent a special case for clinical deception: a case in which it is at least possible to deceive patients without harming them or diminishing their autonomy. Because of this, doctors should be permitted to consider using placebo medications, even if it is true that they could elicit a beneficial placebo effect using bedside manner alone.

Is placebo deception unethical?

The prima facie presumption in medical ethics is that doctors should never deceive their patients in any situation. As the American Medical Association puts it, "A physician shall . . . be honest in all professional interactions, and strive to report physicians . . . engaging in fraud or deception, to appropriate entities."(AMA, 2001). Jackson has argued that deception can be ethical so long as it does not involve actual lying, (Jackson, 1991) and Takarangi and Loftus suggest that deceptive techniques could be carefully used in the clinic to directly benefit patients (Takarangi & Loftus, 2010). But the orthodox view is certainly that doctors have a duty neither to lie to, nor deceive their patients; that deception is to be avoided in its own right as something that is harmful to patients and contrary to the goals of medicine in general.

The reasoning behind this orthodox view proceeds roughly as follows: deception, if uncovered, undermines the trust between the patient and doctor and may distress the patient. Deception can limit a patient's autonomy by preventing him from making informed medical decisions. Deception also diminishes the transparency of the medical consultation process, creating opportunities for unethical doctors to abuse the patient in other ways.

However, medical practice generates a wide range of scenarios in which deception may be on balance beneficial to the patient, not only in the case of placebo prescription but more frequently in cases where a diagnosis is made that would be exceedingly distressing to a patient.

As Daniel Sokol has pointed out, the demands of compassion can sometimes overwhelm the presumption against deceiving patients (Sokol, 2007). If a clinical deception can be considered compassionate—that is, if it can reliably be expected to reduce anxiety or stress, if the deception is likely to succeed and if these goals cannot be met without deception, then that deception may be morally justified.

There certainly may be cases where placebo deception is justified on the grounds that it is sufficiently compassionate relative to the moral costs of deceiving patients. However, I do not wish to advance an 'all things considered' defence of placebo deception. Instead, I wish to argue that, so long as it is limited in the right way, placebo deception is a special case in which the usual presumption against the deception of patients ought to be suspended.

Placebo deception as a special case

When a doctor gives us a placebo, we are deceived into believing something which will become true the moment it is believed: that we will feel better.

Placebo is just one of a range of cases which bear this property. Perhaps the most mundane example are the cases of *encouragement* and *trust*.

Encouragement:

> Imagine you are practicing a speech for your son's wedding, and that I am famous for my excellent wedding toasts. Listening to you, I realize that you are doing a terrible job, but that most of your difficulty seems to come from a lack of confidence. I tell you the speech will be very well received, hoping to persuade you that your preparation is going well. You gain confidence from my encouragement, and as a result the speech is well-received. My deceptive prediction is made true, just so long as you believe in my sincerity.

Trust:

> A and B are strangers who have been forced to participate together in a cooperative task. A does not much like the look of B, and expects B to sabotage the job for his own benefit. B feels the much same about A, and so neither holds high hopes for the success of the project. However, both believe that if they could just forge a relationship of mutual trust, the other would cooperate. To achieve this, A untruthfully says 'I trust you. I know you will do your half of the work.' Now B believes that A will cooperate, and he is willing to cooperate himself. A's untruthful statement is made true, just so long as B believes it.

Earlier, I said that we cannot will ourselves to believe in these beneficial beliefs on our own. Nevertheless, it would be rational for us to believe them, since believing makes them true. In the case of placebo prescription, the doctor *deceives* the patient into one false belief in order to *persuade* him into holding a true belief. This is the property which makes it possible for the deceptive use of placebos to be carried out within the ethical boundaries of medical practice.

In such cases, the doctor's ends justify her deceptive means, provided the following conditions are met: First, the false belief must be required in order to gain the true belief—otherwise, honesty could achieve the same ends. Second, the true belief must be genuinely beneficial to the patient. Finally, this benefit must be assessed by the patient, in terms of his own endorsed ends, rather than on some objective basis by the doctor. For example, my doctor may think that it would benefit me to be vaccinated against measles, but that would not justify his vaccinating me without my knowledge, unless I have asked to be vaccinated, either explicitly or implicitly (say, by visiting a vaccination booth and rolling up my sleeve).

It is important to note that this third requirement will normally be upheld in the case of placebo prescription, provided that the patient has voluntarily sought the assistance of the doctor regarding the alleviation of some set of symptoms, and provided that the doctor assures the patient that it is only those symptoms that will be alleviated. When a patient comes to the doctor complaining of some malady, we can reasonably infer that they want their symptoms to be treated.

It is certainly true that deception prevents a patient from giving fully *informed* consent. Sometimes it is objected that the doctor acts paternalistically in conferring a benefit upon the patient without his consent, whether the patient in fact desires that benefit or not. The American Medical Association's Council on Ethical and Judicial Affairs, for example, holds the view that since patients cannot be fully informed regarding deceptive placebo treatments, these treatments will always be paternalistic and hence unethical (Shah & Goold, 2009). But this objection reveals an exceedingly dogmatic and inflexible understanding of the nature of the relationships between paternalism and consent.

A patient is only treated paternalistically if the doctor confers on him a benefit which he did not request. Paternalism frustrates the stated goals of the patient in order to promote some other goal that the doctor has judged more important. But if the patient, either explicitly or implicitly, demands that his symptoms be alleviated, then there is no way that it can be paternalistic for the doctor to try to meet these goals. Along similar lines, if an addict asks that his friend confiscate his drugs, it cannot be paternalistic to confiscate them. In light of the addict's request, his friend respects his autonomy in taking the drugs, rather than violating it.

It is true that the patient has not given consent (either implicit or explicit) to be deceived about the mechanism of his treatment. He has also not explicitly consented to be given placebo. In this sense a deceptive treatment violates the doctrine of informed consent. But does this matter? Once a doctor receives a patient's consent to treat some ailment, she is not required to obtain separate consent for each step of the treatment process. So long as none of the steps involves any significant cost or harm to the patient, she may execute the treatment however she sees fit. It is not paternalistic for a doctor to unilaterally select an electronic rather than alcohol-based thermometer, or to choose one brand of aspirin over another. We do not require patients to explicitly consent to have their temperature measured with a digital thermometer, because it is not reasonable to expect that his goals will be frustrated when the doctor unilaterally decides to use one.

Choices of this kind cannot frustrate the aims of the patient or cause harm. By the same token, if the doctor decides to advance the patient's stated interests by leading him into a false belief about the nature of his treatment, she does not frustrate his goals or make him any worse off.

A limitation

There is an exception to this defense, however, whenever there is a real medical alternative to the placebo. If there is a meaningful choice that the patient might make between one therapy and another, the deceptive prescription of placebo frustrates the patient's ability to make this choice. In such cases, it is certainly paternalistic for the doctor to use deception to force the patient to accept one reasonable option (the placebo) at the expense of another.

It is therefore a strict moral requirement that placebos are only ever prescribed deceptively when there is no alternative treatment which any reasonable patient might choose. If doctors adhere to this requirement, the patient cannot be a victim of paternalism and his autonomy will be preserved. This requirement also guarantees that the patient does not miss out on optimal medical care.

This requirement places a serious constraint on the ethical use of placebos. To take one obvious example, a doctor should never prescribe placebo for a harmless headache, if there are

analgesics available which the patient might reasonably prefer. Doctors must be limited to prescribing placebo when the symptom to be treated is otherwise untreatable.

It is not all bad news for the placebo-prescribing doctor, however. Placebos can still be used to treat untreatable symptoms of treatable ailments. A patient with a treatable ear infection causing untreatable nausea, for example, could be given antibiotics for the infection and placebo for the nausea.

This is the first and most important of a number of important considerations which must constrain the prescription of placebos if they are to be employed in an ethically defensible way. In the next section, I consider the other major constraints on placebo prescription.

Other limitations on placebo deception

There remain four reasonable objections which are frequently made against the deceptive use of placebos, and these objections circumscribe the ethical limits of placebo prescription.

The first set of objections relates to cases of misdiagnosis. Suppose Susan has misdiagnosed John, thinking that he has untreatable viral conjunctivitis when he actually has a form of bacterial conjunctivitis that can be treated with antibiotics.

When a doctor sends a patient away with placebos, the patient may wrongly believe that his doctor understands his condition. He may be less likely to seek a second opinion from a more competent doctor, even if his condition worsens. He may also unwittingly mislead the second doctor about the 'medications' he is currently taking (Kolber, 2009). Thus, the doctor's misdiagnosis may mean that he misses out on an effective therapy, and her deception can make it much harder for him to obtain that therapy than the misdiagnosis would on its own.

Now, it is important to note that in the case I described at the outset, John is only told to expect relief of discomfort; he is not told to expect underlying symptoms or disease to be cured. Because of this, if his condition worsens he will not be prevented from seeking a second consultation or a second opinion from a different doctor. In this respect John is no worse off than any other patient whose doctor has made the wrong diagnosis.

For some illnesses, however, the divide between symptoms and disease will not be anything like as clear as it is in the case of Susan and John. In these cases, it may be wiser not to use the placebos at all.

The second set of objections concerns cases where the consulting doctor is unable to make any firm diagnosis at all—perhaps the most common case where a doctor might be tempted to prescribe placebo. In these cases it is still true that no active treatment can be ethically prescribed, but it might not be true that no active treatment is available to treat the underlying, undiagnosed ailment.

In these cases, a similar objection appears: placebo prescription requires the doctor to mislead the patient into believing that a diagnosis has been made. If a patient is given placebo, he will be much less likely to revisit his doctor if new symptoms arise which might enable a positive diagnosis (Powell & Bailey, 2009).

These cases are more ethically complex than the cases in which the malady is understood but no treatment is available. But there is still a way to prescribe placebo in these cases. The doctor can prescribe placebo and protect the patient's ability to obtain the best medical care by saying something like this:

I do not have enough information to diagnose your illness, but here are some pills which will help to alleviate your discomfort. If you develop any new symptoms, please come for a follow-up examination.

Pain, discomfort, nausea, anxiety and similar symptoms cannot be misdiagnosed or undiagnosable. If the patient reports feeling pain, then the pain is a candidate for treatment by placebo.

Of course, if the patient's only symptoms are those which might be alleviated by placebo, such as headache, nausea, or anxiety, then this strategy will interfere with the diagnosis of the patient, creating a risk that a positive diagnosis will be delayed or prevented. In such cases, the doctor should avoid using placebo.

The third set of objections concerns the abuse of placebo prescription by unethical doctors. Doctors may be tempted to use placebos to rid themselves of troublesome patients, or to increase the number of patients they can treat. This worry is explicitly mentioned in the American Medical Association's decision prohibiting the use of placebo (AMA, 2007). In these cases, it is thoroughly unethical for the doctor to prescribe a placebo.

As I argued above, part of the reason why placebo prescription is a special type of deception is that the patient is deceived for his own ends, which he declares either explicitly or implicitly when he visits the doctor and asks to be treated. But in cases where the doctor wants to get rid of the patient for the sake of efficiency or convenience, the doctor's ends differ from the ends of the patient.

If the doctor deceives the patient for reasons which are at odds with the patient's goals, then the deception becomes coercive. Onora O'Neill puts it this way:

Victims may want the same ends as their coercers; but that is not the same as sharing those ends, for one who is coerced, even if pointlessly, is not pursuing, nor therefore sharing, ends at all (O'Neill, 1985, p.113).

If the doctor leads the patient to walk away happily with some inert substance, the patient is not sharing the doctor's goal: that he disappear. The doctor has coerced her patient into leaving without being treated, satisfying her own goals but not the patient's.

Another reasonable objection against the clinical placebo is that, if the use of placebo becomes too widespread, its effectiveness will diminish, since patients will develop less of an association between taking medicines and benefiting from their pharmacological actions. If this is true, then the widespread use of placebos would also diminish the benefit of *active* medications, which after all employ the placebo effect as part of their mechanism.

In a similar vein, it may be suggested that the widespread use of placebos would undermine the background level of trust between patients and doctors *in every consultation*, leading patients to suspect that every medicine is inert, even if they agree that it is sometimes appropriate for doctors to prescribe inert medications. This could make it harder to deceive patients, and—again—could undermine the effectiveness of active medications as well as placebos.

Whether or not any of these threats are real is a largely empirical question—a question which, like all the other empirical questions surrounding placebo use, will be very difficult to investigate within current research ethics guidelines. But it is worth pointing out that placebos will never be all that widely used if they are used only within the constraints I have outlined here. Placebos will be a treatment *option* which is never preferred when better options are available. And we can mitigate these risks even more if we are careful to avoid practical pitfalls in our methods of placebo prescription. For example, doctors should be discouraged from 'debriefing' patients once their condition improves, revealing their use of deceptive placebo.

What to do when pushed

There is one more objection to the use of deceptive placebos that imposes a constraint on how they are used: namely, that the use of placebos may undermine the important relationship of trust between the doctor and the patient (Kanaan, 2009).

Indeed, there are cases in which the particular relationship of trust between individual doctors and their patients may be undermined if placebos are prescribed in the wrong way. While the initial placebo deception is a special case which ought not to be considered unethical, it remains unethical for doctors to engage in non-placebo deceptions.

Unfortunately, these kinds of inessential deceptions can quickly creep in if a patient asks directly whether or not they are receiving a placebo. Suppose, for example, that the patient makes a specific enquiry about the nature of his treatment after the doctor has provided a placebo. Or suppose he asks the name of his treatment. Most patients have no interest in the exact pharmacological mechanism of their treatment, but some inevitably do ask such questions. What is the doctor to do in these cases?

Imagine John asks Susan about the active ingredient in the eye drops he has been given. Susan is faced here with a choice: she can either admit that the eye drops are inert, or she can create a new deception, and tell John that the drops contain (for example) an antiviral agent or a steroid. If John tells another doctor that he is on steroids, she may refuse to prescribe John the optimal treatment for some other ailment.

Now, Susan could avoid this outcome by telling John truthfully that the drops contain an active ingredient, salt, that is commonly used to treat eye-related symptoms in infants. In doing this, she would avoid lying, but succeed in deceiving John into holding the belief that the treatment is pharmacologically active and indicated for his symptoms. If he visits another doctor, that doctor will realize that John has been given a placebo. While this is better than directly lying to the patient, there is another important objection: Even if Susan never lies about what the eye drops contained, if John discovers that the drops are not indicated for his adult conjunctivitis, he will know that Susan further deceived him in order to protect her original placebo deception.

Doctors need to be able to recognize the point where further deception would not fall under the moral umbrella of placebo deception. The initial deception involved in placebo prescription is permissible because it furthers the patient's stated aims, but it is not clear that subsequent supporting deceptions advance the patient's aims at all; they merely serve to cover the doctor's tracks. As I argued above, if a deception serves the doctor's aims and not the patient's, it is coercive. Susan

should not be so desperate to defend her initial deception that she engages in additional coercive, non-beneficial deceptions. She should tell John something like this:

I had prescribed you a placebo, but now that you know about it there will be no beneficial placebo effect. We'll have to rely on your natural capacity for healing instead.

Patients may be embarrassed or angry to discover that they have been deceived by their doctors, so these situations ought to be avoided as far as possible. While the patient may prefer to avoid embarrassment, this is not an aim he expresses in seeking out a doctor, and it will be a case of unethical paternalism if he is protected from an uncomfortable confrontation for the sake of his own tranquility.

Placebo for Depression

Perhaps my arguments so far have created the impression that placebos can only be used in the rarest of clinical scenarios. It is true that the constraints I have mentioned greatly limit the range of cases in which a doctor could prescribe placebo to a patient. But the ethical hurdles can be surmounted in one of the most familiar clinical presentations: the depressed patient.

Kirsch suggests both that modern anti-depressants are exceedingly effective and that their effectiveness is entirely grounded in the placebo effect (Kirsch, 2010). If this is correct, then there is a multi-billion dollar industry in the production and prescription of placebos—and while the clinicians in question certainly do not intend to prescribe placebos, the unintentional nature of their actions makes no practical difference to the patients.

If we conceive of depression as a symptom rather than a disease, a doctor will satisfy all the ethical requirements I have given for the deceptive use of placebo when she gives placebo to a depressed patient. I said that placebos should only be given when there is no reasonable alternative, and if Kirsch's results are correct then all the competing pharmacological treatments should be considered placebos*. I also said that placebo should be presented as an agent of symptomatic relief rather than as a cure, and I see no reason why placebo could not be prescribed in this way to a depressed patient. A doctor might say:

I do not know why you are depressed—modern medicine does not understand depression very well. It could be that you have a chemical imbalance or it could be due to stress in your life. Trials have found that 60% of patients feel significantly better when they take an antidepressant, so that is what I am prescribing for you. If your depression gets worse, or if you develop new symptoms, come see me again.

Depression is a common ailment which places a very heavy burden on our society. Currently, assuming Kirsch is correct, doctors currently prescribe placebos for this ailment: expensive placebos with serious unwanted side-effects. We also prescribe these placebos in a way which entirely ignores all the moral limitations I have described—we give patients antidepressants when we could easily send them to therapy or prescribe exercise, we tell patients we are treating the ailment rather than the symptoms, and we overuse the placebo in a way which probably is diminishing its effectiveness. But prescribed correctly, depression provides the clearest case for allowing doctors to intentionally and responsibly prescribe placebos in the clinic.

The ethics of charging money for inert therapies

Placebo treatments have repeatedly been shown to be more powerful when larger prices are imposed on the patients who pay for them (Waber et al. 2008). When people perceive more value in something simply because it has a higher price, it is hard to shake the feeling that they have been duped. And so it is sometimes objected that there is something unethical about expecting patients to pay for inert medications. This objection, however, does not hold up under close scrutiny, at least when it comes to placebo treatments.

Consider first that even active medications have a large placebo component. This is illustrated very clearly by the recent study of Bingel et al. which showed that the effectiveness of a powerful opiate analgesic was reduced by more than 50% when the patient was unaware it had been administered, and subsequently reduced by nearly 100% when the patient was (falsely) informed that the analgesic had been withdrawn (Bingel et al. 2011). If a drug's action is 50% placebo, or 80% placebo, we do not insist that the vendors of these drugs reduce their prices by a corresponding amount.

Consider too that we frequently prescribe medications for which the mechanism is poorly understood, or not understood at all—at best, we have some evidence that these medicines provide benefit compared to an open research placebo, but no evidence for what that benefit is or why the medicine provides it. Thus there is no factual basis for the suggestion that we are normally confined to selling medicines that are known to have a specific pharmacological action. Many drugs on the market could (for all we know) have an entirely psychological mechanism.

* Perhaps a depressed patient could more fruitfully be prescribed exercise or meditation than placebo. Even if that is true, there will be very many cases where this is not feasible, either because the depressed patient is already getting regular exercise or because they are unable to exercise.

In this light, it should be clear that we could only object to the sale of placebo treatments if we thought that placebo benefits were in some sense false benefits. But that cannot be correct, since placebos provide symptomatic relief: something for which patients will willingly and happily pay.

Conclusions

The ethical use of deceptive placebos requires doctors to walk a fine line both medically and morally. They must first ensure that placebo genuinely is the only reasonable treatment available for treating the patient's symptoms. They must make it very clear to the patient that they are only treating the felt symptoms of the ailment, and not the underlying complaint. And most importantly, they must ensure that their ends in deceiving the patient are always shared by the patient, in order that their use of placebo will not be paternalistic and coercive.

Meeting all these needs simultaneously is surely a demanding task, but I doubt that it is too demanding for skilled doctors. The benefits, meanwhile, are significant: there are a large number of cases in which no treatment can be offered or in which no diagnosis can be made. Provided that placebos are as effective at treating symptoms like pain and nausea as I have assumed that they are, the medical and moral difficulties involved in the ethical use of placebo are costs that are worth bearing. We should allow doctors to use placebo, within appropriate ethical constraints.

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