RIFL (2018) Vol. 12, n. 1: 30-41
DOI: 10.4396/20180601

Lying, deception, equivocation and the ethics of prescribing placebos in clinical practice

Marco Annoni
Consiglio Nazionale delle Ricerche (CNR), Istituto di tecnologie biomediche (ITB)
marco.annoni@itb.cnr.it

Abstract In this paper I explore different ways in which doctors can be dishonest in clinical communications. As a case in point, I object to the idea that doctors can prescribe placebos in ways that are not transparent and yet not paternalistic. First, I briefly present evidence demonstrating that placebo effects may modulate a host of clinical outcomes. Second, I argue that doctor's duty of truth-telling in clinical contexts entails two complementary obligations: the one not to lie and deceive (i.e, *the duty of truthfulness*), and the one to inform patients in order to respect their autonomy (i.e, *the duty to inform*). Third, I distinguish different ways in which doctors may violate their duty of veracity. Specifically, I identify two ways in which doctors may fail to uphold the duty of truthfulness (by lying and deceiving), and two ways in which they can instead infringe on the duty to inform (by keeping patients in the dark and by telling half-truths). Based on these distinctions, I conclude that doctors cannot have the placebo cake and eat it too: either they prescribe placebos in a fully transparent manner, or they need to morally justify a paternalistic exception to their duty of veracity.

Keywords: Placebo effects, Medical Ethics, Lying, Deception, Truth-telling

Received 18 January 2018; accepted 14 June 2018.

0. Introduction

Historically, the practice of administering "deceptive", "sham", "fake" or "placebo" treatments has been common in clinical contexts until the mid of the past century (Shapiro and Shapiro 1997). Generally, doctors were using placebos out of considerations of beneficence – i.e. for patients' own good –, and more specifically to provide mental relief, to sustain patient's hope, and to cope with the pressing request of receiving a prescription (Kaptchuk 1998). After World War II, the practice of administering deceptive placebos gradually fell out of favor in clinical settings, mostly because it came to be perceived as incompatible with the newfound value attributed to patient's autonomy and informed consent (Bok 1974; Faden and Beauchamp 1986).

More recently, the debate over the use of deceptive placebos has been revamped due to a growing series of empirical studies demonstrating that even "sham" or "placebo" interventions may have real, quantifiable and sometimes significant therapeutic effects (Brody 1992; Benedetti 2009; Benedetti 2011; Miller and Kaptchuk 2008; Annoni 2013; Kaptchuk and Miller 2015).

For instance, in a study by Kaptchuk and colleagues (2008), patients with irritable bowel syndrome (IBS) were randomized into three groups. Patients in the first group received 'no treatment'. Patients in the second group received placebo acupuncture, but their relationship with the physicians was kept to a bare minimum – 'limited interaction'. Lastly, patients in the third group received the same placebo acupuncture, this time administered by confident, warm and emphatic practitioners – 'augmented relationship'. Results for all outcomes (global improvement scale, adequate relief of symptoms, symptom severity score, and quality of life) confirmed that IBS patients in the 'limited interaction' group reported more relief than those in the control group, but less than those in the 'augmented group'. Improvements were significant: after three weeks, patients reported improvement 27% in the control group, 43% for the limited group, and 62% in the augmented group (Annoni 2013). The magnitude of the response matched that of *alosetron* and *tegaserod*, the two most commonly prescribed drugs for this condition – which have significant, even life-threatening, side effects. This study confirmed that placebos effects can produce clinically significant outcomes and provided the first proof of principle that it is possible to isolate and combine diverse placebo components – i.e. the placebo effect determined by "the provision of a physical therapy" and the placebo effect determined by a warm and "empathic doctor-patient relationship". Similar results have been replicated in other studies, demonstrating the placebo effects may significantly modulate symptoms in diverse conditions such as depression or Parkinson's motor disorders (Benedetti 2009).

These empirical findings, however, raise a host of ethical questions regarding how clinicians ought to present placebos in a way that maximizes their benefits without unjustly violating patients' autonomy and right to informed consent (Brody 1995; Annoni and Miller 2014; Annoni 2015; Annoni and Miller 2016). With respect to this ethical issue, scholars have taken one of the following three positions.

First, some have argued that deceptive placebos are never permissible – even though they might have real therapeutic benefits. This is the position of the American Medical Association (AMA 2006), which in an official "Opinion" dated 2006 stated, «In the clinical setting, the use of a placebo without the patient's knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient. Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use». Thus, according to the AMA, deceptive placebos – i.e. placebos without patient's explicit and prior consent – are always unethical.

Second, some have argued that the prescription of deceptive placebos is no different from other cases of paternalistic deception (Annoni and Miller 2014). On this view, paternalism is often conceptualized as «the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden» (Beauchamp and Childress 2009: 209). As I have explained elsewhere, if this view is coupled with the view that doctors' duty of veracity is *prima facie* rather than absolute, then this is the least problematic position with respect to the ethical implications of deceptive placebos (Annoni 2015). This view entails that, other things being equal, prescribing a deceptive placebo is unethical *unless* doctors can provide a sufficiently compelling moral justification for overriding their otherwise binding duty of truth-telling. Crucially, on this view there is no middle ground: either a doctor prescribes placebos in a fully honest way or he is acting dishonestly, even if it is for the patient's own good.

Thirdly, some scholars have argued that, instead, it is possible to prescribe placebos in ways that are "not transparent" and yet "not paternalistic". For instance, Cohen and Shapiro have observed that,

RIFL (2018) Vol. 12, n. 1: 30-41
DOI: 10.4396/20180601

> When the doctor administering the placebo tells the patient, 'I am giving you a substance that I believe will help your condition,' the crux of the deception according to the traditional understanding is that the doctor expects the patient to assume the substance works on the tissue level, while intending by this utterance to mean it just works psychologically (Cohen and Shapiro 2013: 698).

Gold and Lichtenberg have defended a similar view, claiming that a physician may introduce a placebo to a patient by saying

> 'I am prescribing a pill which research suggests can be of benefit to you. In your circumstances I have reasons to believe that it will work, with a minimum of side effects' […] for the physician who genuinely believes in the therapeutic qualities of the placebo treatment, it would not be considered deception (Gold and Lichtenberg 2014: 221).

The main idea beneath this position is that, in light of what we know about the therapeutic effects of placebos, to say that "this pill will have some benefits for you" is, in the right circumstances, a factually true statement. And since what the doctor is saying is true, then no (paternalistic) deception is involved and no further moral justification is needed. Therefore, doctors administering placebos in such vague and non-transparent ways could harness the benefits of placebos without the need of justifying the use of medical paternalism.
Against this position, in this paper I will argue that, in general, doctors cannot communicate in ways that are not-transparent and yet not paternalistic. Specifically, I will show that the advocates of the non-transparent use of placebos (a) have a one-sided conception of clinicians' duty of truth-telling; (b) ignore that doctors may violate this duty without lying and deceiving; (c) underestimate some crucial aspects characterizing the morality of dishonesty in interpersonal communication.

1. The ambiguity of doctor's duty of telling the truth

According to virtually all accounts and guidelines in medical ethics, today clinicians have a duty of truth-telling or *veracity* in their communication with patients (Beauchamp and Childress 2009). This duty is often conceived as a *prima facie* duty, that is to say, as an obligation that must be fulfilled unless it conflicts, on a particular occasion, with an equal or stronger obligation (Ross 1930; Ross 1939; Beauchamp and Childress 2009: 15). Thus, to say that clinicians have a *prima facie* obligation of veracity entails that, others things being equal, doctors must always tell the truth to patients – at least in ordinary cases.
But what does doctors' duty of veracity entail, in practice? To answer this question we need to define more precisely what "veracity" means in the first place. According to Beauchamp and Childress (2009: 288) veracity «refers to the comprehensive, accurate, and objective transmission of information, as well as to the way the professional fosters the patients' or subject's understanding». This definition is correct but too general, as the commandment "Tell the truth!" can be understood in two different senses (Bok 1978).
In the first sense, it can be understood as meaning: "Do not lie!"; that is to say, as a negative obligation of not telling falsehoods. This negative moral obligation implies that other things being equal clinicians must refrain from *lying* and from *deceiving*. In the second sense, instead, it can be understood as meaning: "Tell the truth!"; that is to say, as a positive obligation to disclose more information. In this latter sense this moral

obligation implies that other things being equal clinicians must disclose all the relevant information required for respecting patients' autonomy and achieve a valid informed consent (Jackson 2001; Beauchamp and Childress 2009; Beauchamp 2010). Based on this fundamental distinction, I shall henceforth distinguish between two complementary *prima facie* moral obligations for clinicians: the *duty of truthfulness* and the *duty to inform*.

These two obligations are strictly interrelated and therefore often confounded. Clearly, a duty to inform someone is premised on the assumption that the information that will be provided will not be false or misleading. Likewise, in order not to convey false ideas, sometimes we need to qualify our statements, providing more information to other speakers. However, as I will show, it is also important to keep them distinct, as they refer to different kinds of communicatory practices that doctors may use in clinical settings.

To sum up, clinicians' duty of telling the truth to patients – i.e. doctors' duty of veracity – can be conceptualized as a general duty composed of two more specific moral obligations: the negative obligation of *truthfulness* and the positive obligation of *informing* patients in order to respect their autonomy and securing informed consent.

With this distinction in place, we are now in a better position to understand what doctors' duty of veracity entails for the doctor-patient communication. More specifically, how can doctors be dishonest in their communications? Answering this question is not trivial, in part because the duty to inform entails that it is possible to violate the duty of veracity without lying and deceiving. To unpack this important claim, in the next sections we shall focus on defying the concepts of (a) deception, (b) lying, (c) and keeping someone in the dark about the truth.

2. How doctors can violate the duty of truthfulness

A minimal requirement for any theory of veracity is to define the concepts of "lying" and "deception". While scholars have proposed several ways of conceptualizing "lying" and "deception", two distinctions are relevant in any account: (a) the one between deception and the provision of false information; (b) and the one between lying and deception.

As for deception, there is a wide consensus that it can be defined as «intentionally causing someone to have a false belief that the deceiver believes to be false» (Carson 2010: 46; Gold and Lichtemberg 2014; Chisholm and Feehan 1977; Bok 1978). On this account, deception requires two conditions. The first is the intention of instilling a false belief in the mind of someone (the *intentionality* condition); the second is that the deceiver must *know* that such belief is *false* (the *epistemic* condition) (Gold and Lichtemberg 2014). More technically,

> A person S deceives another person S1 if, and only if, S intentionally causes S1 to believe X (or persist in believing X), where X is false and S knows or believes that X is false [or, alternatively, S does not believe that X is true] (Carson 2010: 50).

Suppose that you are taking an exam and that you are afraid of not completing it on time. Suddenly, the professor asks "What time is it?". To buy a few minutes, you reply "5.50" whereas your watch indicates "5.55". In this case, you are deceiving the professor because you are intentionally reporting a wrong timing in order to instill a false belief in her mind. Now imagine that you are in the same scenario, but that you are unaware that your watch is 5 minutes late. Again, you reply "5.50", and so you will again instill a false belief in the professor's mind. However, this time you would not be deceiving the professor, as you have no intention of instilling a false belief.

On this account, thus, every deceptive act implies three logical subjects: a deceiver (S), a deceived (S1), and a belief (X) that the deceived entertains because of the intentional behavior of the deceiver (Bok 1978: 13; Carson 2010). Importantly, this definition admits that it is possible to deceive someone with actions *as well as with omissions* – namely by omitting information that would correct an otherwise false belief know by the deceiver to be false. For example, imagine that you and I want to attend a concert. I know that the tickets auctions will start at 9.00 a.m. and that only a few tickets will be available. If you tell me "I will try to get a ticket when the auction starts, at 10.00 a.m.", I might consider not to telling you that the auction will start at 9.00, and not at 10.00, simply because I want to increase my chances of buying the few available tickets. By omitting this information, and thus by letting you retaining a belief that I know is false, I would act on the intention to mislead you, and thus I would be deceiving you (Bok 1978; Chisholm and Feehan 1977; Carson 2010; Gold and Lichtenberg 2014). Therefore, this view of deception is based on three elements: (i) the intentionality condition; (ii) the epistemic condition; (iii) and the recognition that both acts and omissions may count as deceptive.

The second cardinal distinction is between lying and deceiving. Following the previous definition, it is possible to deceive others in different ways trough disguise, body language, speech, and even by remaining silent. What is important is just to act "with the intention of misleading someone", not the means used to this end. But which of these instances of deception also counts as a lie? The answer to this question is notoriously controversial. There is substantial agreement that a lie has three universal features: (i) it is a false statement (Carson 2010; Bok 1978; Chisholm and Feehan 1977); (ii) the liar believes such statement to be false, probably false, or at least not believing it to be true (Carson 2010; Bok 1978; Chisholm and Feehan 1977); (iii) this statement must be stated, asserted or communicated to someone else, usually in the form or verbal or written signs (Bok 1978; Chisholm and Feehan 1977). So, if you just think of replying "5.50" to the professor in the previous example, but then you say nothing, then you would not have lied because you have not stated anything.

But consider a clinician who prescribes a placebo to a patient under the name of "extract of falsissima credulonis". If the patient asks the doctor "Doc is this a placebo?", and the doctor answers "No, it is not", according to this definition the doctor would be lying to the patient. In this case, the doctor is telling a lie ("No, it is not") with the clear intention to deceive the patient (i.e., to instill in his/her mind the false belief that this treatment is not a placebo). Does this mean that lies are just a subclass of deceptive practices? Is the "intention to deceive" a universal feature of lies?

On this point scholars have taken different positions: some maintains that lies are a subclass of deceptive practices (Bok 1978), while others disagree (Carson 2010). Let us call the former view the "broad view" and the latter one the "narrow view". Supporters of the narrow view maintain that it is possible to tell a lie without the intention to deceive others. Carson has argued that there are cases in which the intent to deceive is not required to tell a lie:

> Suppose that I witness a crime and clearly see that a particular individual committed the crime. Later, the same person is accused of the crime and, as a witness in court, I am asked whether or not I saw the defendant commit the crime, I make the false statement that I did not see the defendant commit the crime. I fear of being harmed or killed by him. However, I do not intend that my fake statements deceive anyone. (I hope that no one believes my testimony and that he is convicted in spite of it.) Deceiving the jury is not a means of preserving my life. Giving false testimony is necessary to save my life, but deceiving other is not; the

> deception is merely unintended "side effect" (Carson 2010: 20).

This example demonstrates that the usual "dictionary" definition of a lie as "any intentional deceptive statement which is stated" do not cover all the relevant cases. Aside from their truth-value, statements may also have a *performative* function, as in the case of the witness example. Therefore the "broad view" is wrong: the intention to deceive is not a necessary requirement of all lies. To account for the cases in which we agree that someone is lying, as well for those cases in which a lie is stated without the intention to deceive, Carson has proposed the following definition of "lying":

> A person S tells a lie to another person S1 iff: 1. S makes a statement X to S2, 2. S believes that X is false or probably false (or, alternatively, S does not believe that X is true), and 3. S intends to warrant the truth of X to S1 (Carson 2010: 39).

By saying that "X intends to warrant the truth of X to S1", Carson means that the liar not only tells a statement that she knows to be false, but also that she does so under the promise, oath, or the tacit agreement that she guarantees that what she is saying *is true*. On this view, the key moral problem of telling a lie is that in stating something that we know is false we contravene the basic contract between speakers according to which veracity is the default attitude in communication. This implicit requirement may, in certain contexts, become an explicit one, for example in the form of professional oaths, code of conducts and ethical guidelines. It is because we normally expect doctors to tell the truth (i.e., to warrant the truth of what they say), that when we discover that they have lied we feel betrayed.

Thus, not all lies require an intention to deceive. This view entails that lying and deception differ in two respects. First, lies require stating something false, while deception does not necessarily require a statement: it is perfectly possible to deceive others using only the Morse code. Second, deception always requires the "intention to deceive", while lies can be used for different performative functions[1]. However, it is important to stress that lies without the intention to deceive are borderline cases and that normally lies are told with the clear intention of deceiving others.

3. How doctors can violate the duty to inform

We shall now consider three ways in which it is possible to violate the duty of veracity by violating the duty to inform; they are: (i) keeping someone in the dark by distraction; (ii) keeping someone in the dark by withholding information; (iii) and telling "half-truths".

The first way in which someone (S) may violate a duty to inform is when S acts deliberately to prevent someone else (S1) from learning the truth about X. There are different ways to achieve this objective that, in part following Carson (2010), I shall

[1] Carson (2010: 55) adds a third, more contentious condition for distinguishing between lies and deception, namely that the words "deception" connotes success because «an act must actually mislead someone (cause someone to have false beliefs) it is to count as deception. Many lies are not believed and do not succeed in deceiving anyone». I think that this point is mistaken: deception can be intended without being successful. In the example of the doctor who has performed a wrong lobectomy, she could try to nod emphatically and smile, but it is now guaranteed that this will cause the patient to have a false belief; the patients notes something suspicious, perhaps precisely because the doctor does not answer, and doubts that everything went as planned.

generally label henceforth as "keeping someone in the dark"[2]. We shall now consider two specific ways in which someone S can deliberately act as to prevent someone else S1 to know the truth about X. In all these situations S does not need to state a falsehood or to instill in S1 a belief that she knows to be false in order to be dishonest with S1.

The first way is when S acts as to materially prevent S1 from learning the truth about X, even when such truth is potentially available to S1. Suppose that you are reading the informed consent form to enroll in a placebo-controlled trial. It is a complex text full of details and technical jargon, but in which it is clearly stated that this trial is considered risky and that there is a 75% chance of receiving a placebo instead of an active medication. As a researcher in this study, I am afraid that, if you carefully read these details, then you might reconsider your participation.

Hence, in order to distract your attention, I start with you a conversation about other topics; for example, your favorite holiday destinations. By deviating the conversation and by giving you the impression that there is no time to read everything, you sign the module without reading it with the necessary attention. In this case, you retain your initial and true belief that clinical trials are risky, even though this belief is vague and not well circumstantiated. To act in this way violates the duty to inform participants in clinical research. In this case, my conduct is dishonest and malicious, and yet I have not acted as to instill in you a *false* belief, or to make you retain a false belief that you already had. This example shows that it is possible to be dishonest in professional communication without deception or lying, for preventing someone from discovering the truth about X is not the same «as causing her to have or retains a false belief about X» (Carson 2010: 54).

The second way is when S intentionally withhold some information that prevents S1 to learn the truth about X. Image that we are in the same scenario, but this time I am not disturbing you while you are reading the informed consent form. The form describes the relevant side effects of the experimental medication to be tested. However, I also know that a newly published study suggests that this treatment may have additional side effects. This information could not be included in the disclosure form because of time constraints. Again, fearing that you might not want to proceed upon learning this news, I decide not to disclose what I know about the new study. This time I am not preventing you from understanding an already available information, but I am instead failing to add *more* relevant information. Still, I am not telling a falsehood and, since you already had the belief that "clinical trials are risky", I am not instilling in you a false belief or failing to correct one. Yet, my conduct is clearly in contrast with my obligation to inform you in a way that is adequate to respect your autonomy and to achieve a valid

[2] It is unclear whether the cases of withholding and concealing information should be seen as instances of the more general case of "keeping someone in the dark". For example, Carson (2010: 54) proposes the following tentative definition for "keeping someone in the dark": A person S keeps another person S2 in the dark about X (where X is something that S knows and S1 doesn't know) if, and only if, either: 1. S actively and intentionally prevents S1 from learning about X, or 2. fails to inform S1 about X when either: (i) S knows that S1 wants the information in question and S can easily give it to S1, or (ii) S occupies a role or position in which he is expected to provide S1 with the sort of information in question. Through condition (2.ii) this definition seems to include all those cases in which clinicians are said to "withhold information" from patients. On this point Carson's treatment of the relationship between keeping someone in dark, concealment and withholding of information is unclear. I propose instead to consider the three cases in which someone disturbs the acquisition of, conceal, or withhold information from someone else as special cases of a unique kind: "keeping someone in the dark", i.e. the intentional attempt by someone (S) to prevent someone else (S1) from discovering the truth about X.

inform consent.

These two examples show that it is possible to "keep someone in the dark" without lies and deception but in such a way as to violate the duty to adequately informing patients. But of course, it is also possible to keep someone in the dark through lying and deception, as it is possible to use all the different ways of keeping someone in the dark with the clear intent to deceive. To see how this can occur it is sufficient to replace, in the three scenarios discussed above, the prospective patient in the trial who already knew that such trials are "always risky" with another patient who believes instead that clinical trials have only a therapeutic aim and therefore trial participants do not risk any side effect. Since I know that this latter belief is false, any deliberate attempt of keeping you in the dark about the truth of X (i.e. that clinical trials are risky, and this one in particular), would qualify as a failure to correct your false belief, and thus as an act of intentional deception by omission.

Finally, another way of preventing someone from learning the truth about X is to engage in selective disclosure. Through selective disclosure, I may convey you only "half-truths", eventually distorting the way in which you could interpret or understand some information about X. In partial difference from other cases of omission, the provision of half-truths aims at promoting some false beliefs by *implying* (or by giving the false impression that the speaker is willing to imply) something else than what is literally stated. Image that I am willing to prescribe you a certain "natural treatment" that I invented. In constructing my case, I introduce in my disclosure vague references to the efforts of Big Pharma to silence all studies on the efficacy of natural, readily available and effective products. While in the right context these claims may not be false, by using them in these particular circumstances I intend to put a "spin" on my story, presenting my "natural" remedy as a powerful product still unknown because of the opposition of big corporations. Despite the fact that I am not stating anything false, the way in which I construct my story may still lead you to entertain or reinforce some false belief. Again, also in this case I may or may not deceive you depending on your previous beliefs. If you already believed in what I kept implicit in my story, then you might not entertain any new false idea after our colloquium. In this case, I would be neither deceiving nor lying to you and yet I would still not fulfill my obligation of providing you with an adequate, balanced and objective process of information disclosure.

4. Deception, lies, concealment and the "spillover problem"

Distinguishing at the theoretical level between different ways in which doctors can be dishonest in communication is important because we tend to attribute them different moral weights. However, it also important to underscore that in practice people engaging in dishonest communication usually resort to more than one practice. Dishonest communication often occurs in a continuum and rarely lies and deceptive practices are unique events. More often than not, a lie calls for more lies, while a vaguely deceptive practice may easily lead to stating an open lie.

A classic example of this "spillover problem" is precisely the one in which a physician deceptively prescribes an "impure" placebo – e.g., an antibiotic to "treat" a viral infection. Since this is a "real" medicine, in presenting it to patients an open lie is not required: a vaguely deceptive description will do, just like in the case of non-transparent "pure" placebos. However, if the patient then asks, "Did you prescribe me a placebo?" the physicians would be forced either to disclose the truth ("Yes, I gave you a placebo") or to state an open lie ("No, I did not give you a placebo"). Imagine the case in which, in order to protect the initial deception, the doctor tells a lie but the patient keeps on

asking questions on the compositions, published studies, physiological mechanisms, adverse effects, branding, etc. of the pill. Again, the physician would be forced to tell a lie to "shore up" previous lies. And the more lies will be told, the more lies will be needed. As Bok noted, "the first lie must be thatched with another or it will rain through" (Bok 1978: 25).

Thus, while it is useful to distinguish between lies and deception from a theoretical point of view, it should be stressed that in real cases lies, deception, and other practices of dishonest communication often occur and thrive together, easily spilling one into the other.

5. Concluding remarks

So far I have argued that doctors' general duty of veracity should be understood as comprising both a negative obligation to refrain from lying and deception and a positive duty of disclosing all the information that are needed to respect and promote patients' autonomy. Accordingly, I have proposed to distinguish between what I have labeled as "the duty of truthfulness" and "the duty to inform". Building on this distinction, I have shown that doctors can violate their duty of veracity in different ways.

We can now turn back to the question posed at the beginning: Are the advocates of the "non-transparent use of placebos" right in claiming that it is possible for doctors to communicate in ways that are neither truthful nor paternalistic? Based on the previous analysis I contend that the answer to this question is "No" for at least three reasons.[3]

Firstly, one can argue that not informing the patient that the medication is a placebo qualifies as an act of *deception by omission*, as the doctor would fail to correct a false belief entertained by the patient, i.e., the belief that doctors prescribe only real medications (Annoni 2015). One could reply that clinicians cannot be sure about the particular beliefs that patients entertain, and therefore, that clinicians cannot have "an intention to deceive by omission" in such circumstances. This reply, however, is unsatisfactory. As Bok has observed, therapeutic encounters take place in contexts that are already imbued with beliefs and practices that are shared by both the doctor and the patient:

> The statement that a placebo may help a patient is not a lie or even, in itself, deceitful. Yet the circumstances in which a placebo is prescribed introduce an element of deception. The setting in a doctor's office or hospital room, the impressive terminology, the mystique of the all-powerful physician prescribing the remedy; they convey the impression that the treatment prescribed will have the ingredients necessary to improve the patient's condition. The actions of the physician are therefore deceptive even if the words are so general as not to be lies. Verbal deception may be more direct, but all kinds of deception can be equally misleading (Bok 1974: 20).

Also Cabot (1903: 348) objected to the idea of administering placebos in non-transparent ways, observing that, «a true impression, not certain words literally true, is what we must try to convey». Patients in today clinical settings may reasonably expect that all the remedies that doctors prescribe have been tested in controlled experiments and approved for their efficacy by some regulatory body and according to the same standards used to validate the efficacy of other "standards" treatments. To contravene this shared expectation qualifies as an instance of deception by omission, even if the

[3] In a more succinct form, I have already defended this tripartite argument in Annoni (2015).

words stated by the doctor are sufficiently vague as not be literally false (Annoni and Miller 2014).
Secondly, not disclosing that the prescribed medication is a placebo may also constitute a violation of clinicians' duty to inform patients to respect their autonomy. In fact, knowing that one is assuming or not a real medication is an information that might potentially have implications for one's health and, consequently, for one's autonomous decision-making. As noted by Kolber

> If a person ends up in the emergency room in an unfamiliar locale, he wants to give his treating physician the most accurate information possible about his current medication. With [incomplete] information, the doctor may decline to use highly effective treatments out of fear that it could interact with the medication the patient mistakenly thinks he is taking (2009: 25).

Hence, doctors resorting to "non-transparent" placebos would still act dishonestly and violate their duty of veracity, even though they would be so not because they lie or deceive, but because they strategically "keep the patient in the dark" with respect to some relevant information.
Finally, there is also a practical reason for why it is not recommendable to consider the use of non-transparent placebos as distinct from the one of deceptive placebos, namely, that concealment tends often to "spillover" into deception and lying. Assuming that the physician will not be able to write a prescription for the placebos, how will she introduce the treatment? How will the pills be labeled? What if the patient starts asking questions about the active principles and the mechanisms of action? What if she wants to check online the possible side effects of the prescribed medications? In sum, even if the doctor's statement may not be literally deceptive – although it can be *contextually* so – there is always a risk that an initial concealment or a "half-truth" could then easily lead to the need of resorting to an explicitly deceptive practice such an open lie.
In conclusion, the view for which it is possible to avoid the traditional ethical hurdles of justifying a deceptive placebo cannot be escaped by claiming that placebos can be administered in ways that are neither truthful nor deceptive: either the administration of a placebo is fully open-label, or it is paternalistic and thus it requires to be morally justified in some other ways.

References

American Medical Association (AMA) (2006), «Code of Ethics Opinion 8.083. Placebo Use in Clinical Practice», from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8083.shtml

Annoni, Marco (2013), «Highlights from the 2013 Science of Placebo thematic workshop», in *Ecancer*, 7, 346, from http://ecancer.org/journal/7/346-highlights-from-the-2013-science-of-placebo-thematic-workshop.php

Annoni, Marco, and Miller, Franklin G. (2014), «Placebo in clinical practice: an ethical overview», in *Douleur et Analgésie*, n. 27, pp. 215-220.

Annoni, Marco (2015), «Exceptional lies: The ethics of deceptive placebos in clinical settings», in *Biblioteca della libertà*, n. 213, pp. 1-17.

Annoni, Marco, and Miller, Franklin G. (2016), «Placebo Effects and the Ethics of Therapeutic Communication: A Pragmatic Perspective», in *Kennedy Institute of Ethics Journal*, n. 26, pp. 79-103.

Beauchamp, Thomas L., and Childress, James F. (2009), *Principles of Biomedical Ethics*, Oxford University Press, New York and Oxford.

Beauchamp, Thomas L. (2010), *Autonomy and Consent*, in Miller F. G. and Wertheimer A. (eds.), *The Ethics of Consent*, Oxford University Press, New York.

Benedetti, Fabrizio (2009), *Placebo effects: Understanding the mechanisms in health an disease*, Oxford University Press, New York 2015[2].

Benedetti, Fabrizio (2011), *The Patient's Brain: the neuroscience behind the doctor-patient relationship*, Oxford University Press, New York.

Bok, Sissela (1974), «The Ethics of Giving Placebos», in *Scientific American*, n. 231 (5), pp. 17-23.

Bok, Sissela (1978), *Lying: Moral Choices in Public and Private Life*, Vintage Books, New York 1999.

Brody, Howard (1992), *The Healer's Power*, Yale University Press, New Haven.

Brody, Howard (1995), «Placebo», in *Encyclopedia of Bioethics*, edited by W.T. Reich, pp. 1951-1953, Simon & Schuster Macmillan, New York.

Cabot, Richard C. (1903), «The Use of Truth and Falsehood in Medicine: an Experimental Study», in *American Medicine*, n. 5, pp. 3444-3449.

Carson, Thomas L. (2010), *Lying and Deception. Theory and Practice*, Oxford University Press, Oxford.

Chisholm, Roderick M., and Feehan, Thomas D. (1977), «The intent to deceive», in *Journal of Philosophy*, n. 74, pp. 143-159.

Cohen, Shlomo, and Shapiro, Haim (2013), «"Comparable Placebo Treatment" and the Ethics of Deception» in *Journal of Medicine and Philosophy*, n. 38, pp. 696-709.

Faden, Ruth R., and Beauchamp, Thomas L. (1986), *A History and Theory of Informed Consent*, Oxford University Press, New York.

Gold, Azgad, and Lichtenberg, Pesach (2014), «The moral case for the clinical placebo», in *Journal of Medical Ethics*, n. 40, pp. 219-224.

Jackson, Jennifer (2001), *Truth, Trust and Medicine*, Routledge, London and New York.

Kaptchuk, Ted J. (1998), «Intentional Ignorance: a history of blind assessment and placebo controls in medicine», in *Bulletin of the History of Medicine*, n. 72, pp. 389-433.

Kaptchuk, Ted J., Kelley John M., et al. (2008), «Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome», in *British Medical Journal*, n. 336, pp. 7651.

Kaptchuk, Ted J., Miller, Franklin G. (2015), «Placebo Effects in Medicine», in *New England Journal of Medicine*, n. 373, pp. 8-9.

Kolber, Adam J. (2007), «A Limited Defense of Clinical Placebo Deception», in *Yale Policy Review*, n. 26, pp. 75-134.

Miller, Franklin G., and Kaptchuk, Ted J. (2008), «The power of context: Reconceptualizing the placebo effect», in *Journal of the Royal Society of Medicine*, n. 101, pp. 222-225.

Ross, William D. (1930), *The Right and the Good*, Claredon, Oxford.

Ross, William D. (1939), *The Right and the Good*, Claredon, Oxford.

Shapiro, Arthur K., and Shapiro, Elaine (1997), *The Powerful Placebo: From Ancient Priests to Modern Physician*, The John Hopkins University Press, Baltimore.