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Lie to Me

The Ethics of Truth-telling and Deception for Oncology

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To anyone in pain.

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Abstract

This dissertation deals with the ethics of truth telling and deception in medicine. Should clinicians tell the truth, even if the truth may cause patients irremediable psychological and physical harm? Are lies told with a benevolent intent always blameworthy? Are deception and concealment less culpable than lying? Should patients be informed that the medicine they are taking “with so many benefits” is just a placebo? How can physicians determine, between two alternative verbal disclosures, which one provides the optimal balance between truthfulness and beneficence? In this dissertation I endeavour to elaborate an answer to these and other questions by setting forth a normative theory of truth telling and benevolent deception for medical professionals, and especially for those operating in clinical oncology. Throughout this work I defend two main ideas. First, clinicians have a duty of veracity in all their professional communications, but in exceptional cases other considerations of beneficence and compassion may override this *prima facie* obligation. Second, clinicians may resort to clinical deception only if they have ruled out all other truthful courses of action and would be ready to hypothetically defend and actually disclose their behavior in public. This view, I contend, has several advantages over competing accounts and provides clinicians with a practical way of approaching moral dilemmas about truth telling and deception in clinical medicine.

Introduction.

There are only two mistakes one can make along the road to truth;
not going all the way, and not starting.

Buddha

(i) Truth telling, deception, and moral dilemmas in medicine

The view that doctors must be honest with patients is relatively recent. For instance, Hippocrates, the father of Western medicine, taught that doctors must “conceal most things from the patient [...] Give necessary orders with cheerfulness and serenity [...] revealing nothing of the patient’s future and present condition”. As the following quote vividly portrays, after more than two thousands years doctors were still following these teachings:

A woman with terminal breast cancer asked her doctor why her headaches persisted. When the doctor said it was probably nerves, she asked why she was nervous. He returned the question. She replied, “I am nervous because all tests have stopped, nobody wants my blood, and I get all the pills I want. The priest comes to see me twice a week, which he never did before, and my mother-in-law is nicer to me even though I am meaner to her. Wouldn’t this make you nervous?” There was a pause. Then the doctor said, “You mean you think you are dying?”. She said, “I do”. He replied, “You are”. The she smiled and said, “Well, I broke the sound barrier; someone finally told me the truth” (Hackett 1976: 372-3, quoted in Jackson 2011, 95).

This scenario has been fairly typical in oncological settings until a few decades ago, when patients who had a terminal prognosis were often left in dark about the severity of their clinical condition. This practice was justified according to the same rationale that since Hippocrates has provided moral guidance for clinical medicine: “to help, or at least to do no harm”. Since knowing the truth may harm patients emotionally, psychologically and even physically, for the most part of the history of medicine doctors were expected to conceal bad news out of considerations of compassion and nonmaleficence. Yet, –as in the above quote– also benevolent lies can sometimes harm by creating a climate of corrosive suspiciousness; Tolstoy (2009, 32) has explored this possibility in *The Death of Ivan Ilych*, as he wrote

The main torment for Ivan Ilych was the lie, that lie for some reason acknowledged by everyone, that he was merely ill and not dying, and that he needed only to keep calm and be treated, and then something very good would come of it. While he knew that whatever they did, nothing would come of it except still more tormenting suffering and death. And he was tormented by that lie, tormented that no one wanted to acknowledge what they all knew and he knew, but wanted to lie to him about his terrible situation, and wanted him and even forced him on the eve of his death, the lie that must needs reduce the dreadful, solemn act of his death to the level of all their visits, curtains, sturgeon dinners [...] was terribly tormenting for Ivan Ilych [...] This lie around and within him poisoned most of all the last days of Ivan Ilych’s life.

In the case of Ivan Ilych and of the woman in the first quote, the use of benevolent deception eventually turned into a double-edge sword: not only it prevented both patients from deciding how, where and with whom they wanted to die, but it also colored the already dreadful experience of being terminally ill with a further shade of loneliness and doubt.

Should we thus conclude that lying to a dying patient for “her own good” is always wrong? Maybe it is so; but consider the case in which a patient with a ruptured aortic aneurysm is rushed to the operating theatre. “The anaesthetist knows the patient’s chances of survival are poor. Just as preoxygenation is about to begin, the distressed patient asks ‘I am going to be all right, aren’t I, doctor?’” (Sokol 2007, 984). What should the unhopeful anaesthetists reply? If she “tell the truth, the whole truth and nothing but the truth”, then she might increase the patient’s stress-levels, hence hindering the attempts to save her life. If, instead, she replies, “You will be OK!” she would tell a lie. Should the anaesthetist be honest? Or should we conclude that clinicians ought not to be honest whenever the difference between truth telling and lying may turn into the difference between life and death?

In clinical settings, however, moral dilemmas about truth telling do not always concern patient’s wellbeing—at least not directly. Consider the case in which an oncologist must disclose to the parents that their only son has suddenly passed away during the night. Upon hearing the sad news, the mother asks, “Doc, at least, was he in pain?”. Sadly, the oncologist knows that the answer is affirmative but, to spare further and unnecessary suffering to the parents, he replies, “No, we sedated him; he just fell asleep”. Is this benevolent lie morally permissible? Does clinicians’ duty of veracity entail that they should always negotiate between truthfulness and its consequences? Or does it entail that they should always be truthful and be ready to help others to cope with the truth in the best and humane way possible?

Moreover, while all the above questions regard dramatic scenarios, part of the difficulty in exploring the nature of clinicians’ duty of truth telling derives from its ubiquity in

ordinary situations. Doctors, like everybody else, must often decide over issues of veracity that are perhaps less momentous, and yet equally complex from a moral point of view. Consider this case, in which the provision of an inert placebo leads to the following dilemma:

CG is an 89-year-old female nursing home resident with carcinoma of the breast [...] GC believes her cancer has spread to her bones despite evidence of the contrary. During the admission process, the hospice nurse noted that GC was taking “Cebocap” for pain, which was written by her primary care provider. The nurse was unfamiliar with this medication and looking it up found that it contains “no active pharmaceuticals”—that is, it is a placebo. The patient states, “I can’t live without my pain medication”, stating that is quite efficacious for her bone pain. In the hall, the patient’s daughters tell the nurse that they know their mother is taking a placebo and do not want it changed. Nor do they want their mother told.

Should the hospice nurse tell the patient that she is taking a placebo? On the one hand, she knows that the patients and her caregivers are fully satisfied with her current regime; on the other hand, instead, she fears that patient’s autonomy is threatened by the administration of the deceptive and inert pill (Baumrucker et al. 2011, 284). This dilemma is further complicated by a series of new researches on placebo effects that suggest that there is a chance for this patient to experience real pain if she has sufficiently strong expectations in this sense (Colloca et al. 2008). If the doctor withdraws the placebo, CG is likely to be in *real* pain, and this would require the doctor to prescribe her *real* analgesics with all their *real* side effects. Hence, should the doctor tell the truth about the placebo or not? Is the “white lie” associated with the administration of deceptive placebos ever justifiable in clinical contexts?

As Bok (1978) noted, although we are to some extent all familiar with duplicity in our everyday and public life, the morality of truth telling is elusive, and sometimes it can be very difficult to decide what we ought to do. Moral dilemmas about veracity are even more problematic in clinical contexts, where the choice between truthfulness and falsehood may become the choice between life and death, compassion and cruelty, relief and suffering. Do clinicians have a duty to tell the truth? And if so, what should clinicians do when this duty conflicts with their other obligations of beneficence and nonmaleficence? Is benevolent deception ever permissible in clinical medicine? And if so, how can it be morally justified?

(ii) Objectives, summary of the main claims, and plan of the work

The objective of this work is that of elaborating a well-crafted theory of how we ought to think about clinicians' duty of truth telling in clinical contexts. This theory aims at satisfying two general desiderata. First, it must provide clinicians with a set of theoretical tools useful to identify and analyze all the different moral dilemmas that may arise in relation to clinicians' duty of veracity. Second, this theory must provide clinicians with an adequate set of theoretical resources to handle and possibly resolve these moral dilemmas, hence deciding what ought to be done in each specific case. Mine is thus essentially a theoretical endeavor: although I occasionally discuss empirical studies, I do so only to support or specify the main claims that I articulate in the form of a series of logically concatenated, and hopefully correct, arguments.

Throughout this dissertation I draw extensively from examples in oncology. While the following account may be applied to other areas of clinical medicine, oncology provides a vantage point for elaborating a normative theory of clinical truth telling for two complementary reasons. First, oncologists face on a daily basis an ample range of moral dilemmas about issues of veracity and falsehood. Any theory of truth telling that serves well the needs of oncologists will also serve well the needs of all other medical professionals. Second, historically oncology has been the area of medicine that has shaped the most public attitudes toward truth telling in medicine. It has been for oncology that the ethics of clinical truth telling has been first explored in depth; and it has been in oncological settings that researchers have first inquired to see whether public attitudes toward clinical truth telling were or not shifted in consequence of the rise of individual autonomy in bioethics (see 1.1).

This dissertation places itself within the field of clinical ethics, as it focuses squarely on the moral implications that truth telling and deception have in and for the doctor-patient relationship. While my view has implications also outside the domain of clinical medicine, in this dissertation I limit my analysis only to moral dilemmas arising in this latter context. Thus,

I do not discuss—at least not directly—the moral implications of truth telling and dishonesty in research and public health ethics. Also, I do not discuss other issues that, while legitimately belonging to medical ethics, would have extended too much the breadth of my inquiry. These other issues include—among other things—patients’ obligations of truth telling toward doctors; clinicians’ obligation of veracity toward scientific institutions and insurance companies; and the ethics of scientific fraud or misconduct.

In the following pages I defend two main claims. First, I contend that other accounts in medical ethics have severe shortcomings that might lead clinicians to evaluate the moral permissibility of a deceptive act in suboptimal and biased ways. Second, I identify the source of these theoretical and practical limitations in the way in which other account under-theorize the morality of deception in medicine. As I hope to demonstrate, without a thorough understanding of the morality of deception and truth telling in general it is not possible to elaborate a satisfactory account of clinician’s duty of veracity in clinical medicine.

Unlike other accounts, in what follows I combine theoretical tools from medical ethics and moral philosophy to elaborate an “exceptionalist”, “balanced”, and “procedural” view of the moral permissibility of clinical deception built around the concept of “public justification”.

This view is “exceptionalist” because it conceptualizes clinician’s obligation of veracity as a *prima facie* duty that allows for qualified exceptions; it is “balanced” because it recognizes in the preservation of patients’ trust and in the respect of patients’ autonomy two equally important concerns for evaluating the morality of a deceptive act; it is “procedural” because it indicates a three-tier process whereby clinicians can articulate their reasons in less biased ways; and, finally, it is grounded in the concept of “public justification” because it revolves on the idea that deception in clinical contexts is morally permissible only if those who are proposing it would be ready to hypothetically defend and actually reveal their deceptive act in public.

This dissertation is divided in two parts. In the first one I set forth my answer to this general questions: Do clinicians have a duty to tell the truth to their patients? And if so, what does it mean for clinicians to respect this duty of veracity? This first part represents the theoretical core of this dissertation and is further divided in five chapters.

Chapter one introduces the view that clinicians have a *prima facie* duty of veracity in their professional communications. Here I synthetically reconstruct how honesty and veracity have emerged in contemporary biomedical ethics, analysing four classical arguments about clinicians' duty of veracity. I then propose to conceptualize this duty as a *prima facie* duty composed of two *prima facie* obligations: the duty not to lie and deceive, and the duty to inform patients in order to respect their individual autonomy.

In chapter two I explore different ways in which clinicians can violate these *prima facie* obligations by deceiving, lying, and keeping someone in the dark, discussing whether these different ways of being dishonest have intrinsically different moral weights.

In chapter three I inquire into the reasons why deception is *prima facie* wrong in medicine. Here I analyze two arguments according to which deception is *prima facie wrong* because it disrespects patients' autonomy and because it threatens patients' trust. Then, I clarify the relationship between these two rationales, arguing that they both provide necessary conditions for having a meaningful therapeutic relationship. Finally, I introduce and discuss the moral phenomenon of the "discrepancy of the perspectives", that is, our tendency to differently appraise the moral implications of the same deceptive act depending on which of the two perspectives we assume: the one of the deceiver or the one of the deceived.

In chapter four I analyze the limits of other accounts that have been elaborated to deal with the moral implications of deception in clinical medicine. Here I explain why all positions based on a categorical ban of deceptive practices are unsatisfactory, and why the

dominant perspective in today medical ethics—i.e. Beauchamp and Childress’s “justified hard paternalism”—is inadequate if applied to moral dilemmas over issues of clinical deception.

Finally, in chapter five, I advance my proposal that deception in clinical settings is ethically justifiable in exceptional cases, provided that the following conditions are met: that other truthful courses of action have been ruled out; that the proponent would be ready to defend her conduct in public; and that the deceptive act is publicly disclosed. Whenever these conditions are in place, I argue, benevolent deception may be morally permissible.

In the second part I apply and further extend the theoretical framework previously elaborated to determine how clinicians’ *prima facie* obligation of veracity ought to be specified in the light of new discoveries about placebo and nocebo effects. This second part is divided into two chapters. Chapter six discusses the ethics of deceptive placebos in clinical contexts. After providing a synthetic reconstruction of the main coordinates of the debate, I analyse a series of arguments that have been used to argue for or against the clinical use of deceptive placebos, finding them all wanting. I then explain why my perspective provides a better starting point to conceptualize the ethics of clinical placebos in clinical settings.

Finally, in chapter seven, I discuss the ethics of using doctor-patient communication in non-deceptive ways to modulate patients’ health-outcomes through placebo and nocebo effects. Here I introduce the concept of “therapeutic communication” (TC) and then I identify in *veracity*, *helpfulness*, and *pragmatism* three morally relevant coordinates for the ethics of TC. I conclude by presenting two cases in which the implementation of techniques of TC may grant clinicians with a low-risk and cost-effective way of providing superior care to patient without the need of resorting either to deception or to physical placebos.

Part I Veracity and Deception in Clinical Ethics

It is commonly assumed that clinicians have a moral duty to tell the truth about patients' diagnoses, prognoses, and the risks and benefits of the treatments they administer. However, even if one concedes that clinicians have a duty of veracity in their professional communications, one may still disagree on what counts as "deception" or "lying" in particular circumstances; on why dishonesty in medicine is morally blameworthy; on whether there are morally justifiable exceptions to the duty of veracity, and on how they can be identified.

In the first part of this dissertation I outline my theory that it is morally permissible for clinicians to make exceptions to their duty of veracity. While this position is *per se* not controversial, my proposal significantly differs from other accounts in two crucial respects. First, I combine theoretical tools from both medical ethics and moral philosophy with the aim of taking into account the morality of deception from a broader theoretical perspective. This approach, I maintain, allows for identifying both the theoretical limits of other positions as well as the possible strategies to overcome such limitations.

Second, my proposal requires that clinicians resorting to clinical deception ought to articulate their reasons not only at the level of their private consciousness—a process that is likely to lead to biased moral judgments—but also at others "levels of publicity", asking which deceptive act, if any, would conceivably withstand a process of public justification. As I demonstrate in the next chapters, by applying this perspective it is possible to avoid many of the shortcomings hindering other accounts while at the same time allowing clinicians to take better moral judgments about whether deception is morally permissible in clinical contexts.

1. Veracity as a *Prima Facie* Duty

It is always the best policy to speak the truth,
unless, of course, you are an exceptionally good liar.

Jerome K. Jerome

(1) Introduction

This chapter introduces the view that clinicians have a *prima facie* duty of veracity in their professional communications. Section (1.1) provides a synthetic reconstruction of how honesty and veracity have emerged in contemporary biomedical ethics. Then, section (1.2) discusses and refutes four classical arguments according to which clinicians' duty of veracity (1.2.a) is unrealistic because the "whole truth" cannot be known, communicated and understood; ought to be limited because (1.2.b) patients do not want to know the truth or (1.2.c) they can be harmed by the truth; (1.2.d) should be absolute because lies and deception are always morally wrong. Next, section (1.3) introduces Ross's concept of *prima facie* duty, while section (1.4) proposes to conceptualize clinicians' obligation of veracity as a *prima facie* duty composed of a *prima facie* obligation not to lie and deceive; and of a *prima facie* obligation to inform patients as to respect their individual autonomy.

(1.1) Deception and veracity in medical ethics: from paternalism to autonomy

Honesty, veracity and truthfulness are very recent additions to medical ethics. Traditionally, medicine has been focused on beneficence and non-maleficence. On the classical view, words had the power to increase and alleviate the suffering of patients just like physical and pharmacological interventions. Accordingly, their provision was equally disciplined by a commitment to "help and do not harm". In those cases in which the truth was judged unbearable, too distressing or in conflict with healing, physicians and healers were usually permitted—and often expected—to act paternalistically. For the greatest part of the history of medicine, thus, untruthfulness, concealment, and benevolent deception were considered legitimate tools of the healing arts on a par with physical remedies.

It is therefore unsurprising that ethical, legal and deontological codes have ignored truthfulness and veracity until a few decades ago. A drastic change occurred after the

Nuremberg trial, when the principle of respect for autonomy was introduced to protect persons from medical abuses and exploitation (Faden and Beauchamp 1986). With the following emergence of informed consent as the new legal and ethical hallmark of the patient-doctor relationship, truthfulness became a pivotal requirement in medical settings (Bok 1978, 233).

The rise of truthfulness and autonomy in contemporary biomedical ethics has proceeded at different paces in different cultural contexts: in countries centered on family and community values like Japan and Italy the paternalistic practice of withholding a cancer diagnosis has remained unquestioned until very recently;¹ in the Anglo-American context, instead, changes have been more dramatic. A 1961 study found that 88% of American physicians avoided disclosing a cancer diagnosis (Oken 1961); in 1979—after only eighteen years—another study found that only 2% of doctors declared to withhold information from their patients (Novack et al. 1979).²

Ethical codes and guidelines have been less reactive in incorporating explicit references to veracity. The Hippocratic Oath does not mention an obligation to veracity; nor does the 1948 Declaration of Geneva by the World Medical Association (WMA). The American Medical Association (AMA) Principles of Medical Ethics did not contain a reference to honesty until its 1980 revision. Today, however, deceiving and lying to patients is

¹ The global shift from a paternalistic model centred on beneficence to one centred on the respect of individual autonomy is yet to be completed. For example, in many countries clinicians can still withhold relevant information for paternalistic reasons, and the so-called “therapeutic privilege” is still a frequently used option. In Italy, for example, the 1989 Deontological Code stated, “the physician might evaluate, specifically in relationship with the patients’ reactions, the opportunity not to reveal to the patient or to mitigate a serious or lethal prognosis” (Codice Deontologico, 27). Similarly, in 2003, the Brazilian Code of Medical Ethics stated that “it is prohibited for the physician not to let the patient know the diagnosis, outcomes and risks and aims of the treatment, except when direct communication to them may cause harm, and one must in this case make the communication to the legal persons in charge” (Da Silva et al. 2003). These differences are likely to depend on cultural variables. As noted by Surbone (2006, 945), in family and community-centred societies “the world autonomy was typically perceived as being synonymous with isolation rather than freedom”. For an informative account of the evolution of public attitudes towards truth telling see also Surbone et al. (2004).

² Importantly, in 1973 in the US passed the Patient Bill of Right, in which it was stated, “the patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can reasonably be expected to understand” (American Hospital Association 1973, 41; quoted in Jackson 2001, 23).

considered unethical because it threatens the professional and social status of medicine, it compromises the bond of trust between doctors and patients, and it infringes on the respect for patients' individual autonomy and right to informed consent (Beauchamp and Childress 2009; Bok 1978; Jackson 2001). Significantly, the WMA code of medical ethics now states that a physician shall "deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who [...] engage in fraud or deception" (2006). In many countries, the use of benevolent deception may now lead to lawsuits for medical malpractice.

Thus, today it is assumed that clinicians ought to be honest in their professional communications with patients. Does this mean that lies and deception always morally wrong in medicine? Are there excusable exceptions? To begin answering these questions we shall now first look at four classical arguments concerning clinicians' duty of truth telling.

(1.2) Challenging the view that clinicians have a duty of veracity

To understand what clinicians' obligation of veracity entails, in this section we shall analyze four classical arguments that have been used to hold that such duty should (i) be abandoned because the "whole truth" cannot be known, communicated and understood; limited because (ii) patients' do not want to know the truth or (iii) they could be harmed by the truth; or (iv) made absolute because lies and deception are always morally wrong. Charting the limits of these classical arguments will help setting the stage for the subsequent exploration of the morality of deception in clinical medicine.

(1.4.a) First argument: clinicians cannot tell the truth because the truth cannot be told

The first argument is that an obligation of veracity entails insurmountable epistemological difficulties: in order to have a duty of truth telling—it is argued—one must first be able to know what the “truth” is and to fully communicate it. Translated in the terms of contemporary epistemology, to “know what the truth is” amounts to have either a satisfactory theory and/or a criterion for recognizing the truth, and the capacity to know it. However, since it is impossible to know what the “truth” is, then it is absurd to impose on anyone a duty of veracity. The following quote, taken from an influential 1935 article, perfectly summarizes this argument and its implications for the doctor-patient communication:

Above all, remember that it is meaningless to speak of telling the truth, the whole truth, and nothing but the truth to a patient. It is meaningless because it is impossible—a sheer impossibility. [...] Since telling the truth is impossible, there can be no sharp distinction between what is true and what is false.

[...] Far older than the precept, “the truth, the whole truth, and nothing but the truth,” is another that originates within our profession, that has always been the guide of the best physicians, and, if I may venture in prophecy, will always remain so: So far as possible, do not harm. You can do harm by the process that is quaintly called telling the truth. You can do harm by lying. [...] But try to do as little harm as possible (Henderson 1935, quoted in Bok 1978, 12).

The conclusion of this argument is that doctors could not—and thus *should* not—have a duty of veracity toward patients. This argument is based on two assumptions. The first is that a duty of truth telling presupposes that clinicians can effectively know what “the truth” is; the second is that by “the truth” what is meant is a state of complete and certain information. Despite its philosophical tone, this argument points to very practical difficulties. It can hardly be disputed that one can know, communicate or understand the “whole truth”. However, from this conclusion it does not follow that imposing on clinicians a moral obligation of veracity is unrealistic. In fact, this argument is based on two fundamental misunderstandings.

First, it confounds clinicians' duty to provide accurate and complete information to patients with an unrealistic duty to provide *complete* and *certain* information. But, of course, physicians are under no obligation of disclosing to patients every irrelevant detail concerning their clinical situation and care (e.g. the color of their bandages), nor of being open about everything that is passing in their minds, (e. g. their musical preferences).³ Rather, clinicians have an obligation to disclose information that can be useful to improve patient's care and are needed to respect patients' autonomy.

In this sense, to be "valid" patients' consent should be "sufficiently capacitated, informed and voluntary consent" (Eyal 2011), not absolutely or completely informed. As Beauchamp and Childress (2009, 101) observers, "to restrict adequate decision making by patients and research subjects to the ideal of fully or completely autonomous decision making strips their acts of any meaningful place in the practical world, where people actions are rarely, if ever, fully autonomous". On each occasion, information should be tailored to match patients' specific needs, responses, and views. This can be challenging; but no challenge provides a justifiable excuse for doctors not to engage in truthful communication (Bok 1978). Not matter how hard communication and mutual understanding may appear, clinicians must always try to convey to patients adequately complete and relevant information.⁴

Second, the first argument mistakenly conflates *truth* with *truthfulness* (Bok 1978, 6-13). As an epistemic concept—and in a very simplified sense—"truth" refers to our knowledge and

³ Clinicians have no duty of absolute openness or candour (Jackson 2001; Beauchamp and Childress 2009). Sometimes doctors must withhold information to protect confidentiality and privacy. The attitude to be completely open about one's thoughts, feelings, preferences, etc. is rather to be conceptualized as part of the virtue of candour. For a discussion of this distinction, see Jackson (2001, 35-36) and Bok (1989).

⁴ Furthermore, this argument is frequently taken as the starting point to argue that a commitment toward truth telling entails two unsolvable difficulties. The first is that the "whole truth" cannot be communicated. In fact, telling "the whole truth" about anything (e.g. a medical diagnosis) would imply a description of every detail, no matter how small or insignificant, about something arguably connected with everything else. Clearly, this task is impossible because it would require an infinite amount of time. The second issue is that patients cannot understand the whole truth. Medical information is too technical and complex to be understood by patients who are emotionally stressed, scientifically illiterate or cognitively impaired. This poses a genuine difficulty on how physicians can fulfil their obligation of truth telling as well as a challenge for the theory of informed consent (Joffe and Truog 2010). In order to be valid an act of consent needs to be informed. Bu since it is impossible to *fully inform* someone about something—it is argued—then no consent can ever be *fully valid*.⁴

beliefs. As a normative concept, instead, truthfulness refers to our *intention* to communicate to others what we believe is true or false. The two concepts are necessarily related and yet distinct. It is possible to communicate false information in a perfectly truthful way (e.g. someone stating that “the earth is flat” in the 13th century). Likewise, it is possible to be truthful about one’s own ignorance (“I do not know what is your condition”) or uncertainty (“I am not sure when it will heal”). Truthfulness as a normative concept is thus logically independent from truth as an epistemic concept. Hence, one can debate over the moral implications of truthfulness without first solving the philosophical quandaries related to the concept of “truth”.

Therefore, the first argument is based on two fundamental misunderstandings. Even if the “whole truth” cannot be known, communicated and understood, clinicians may still have a duty of veracity. This duty should not be confounded with an absolute duty to inform. While in many cases fulfilling an obligation of veracity implies fulfilling also an obligation to inform (and vice versa), this should not necessarily be the case. Thus, in order to justify the view that doctors do not have duty of truthfulness, one cannot resort to the argument that the old precept of telling “the truth, the whole truth, nothing but the truth” imposes insurmountable epistemic and practical obstacles.

(1.4.b) Second argument: patients do not want to be told negative truths

The second argument is that most patients do not want to be told bad news. Ptacek and Eberhardt (1996) define a “bad news” in medicine as information that “results in a cognitive, behavioral or emotional deficit in the person receiving the news that persists for some time after the news is received”. Indeed, medicine is fraught with potential bad news, especially in areas such as obstetrics, pediatrics, intensive care, and oncology. A cancer diagnosis is the

paradigmatic example of a bad news that patients may not want to be told. In these cases—the argument goes—fulfilling an obligation of truthfulness would run against patients’ preferences and would thus not respect their autonomy. Thus, the obligation of veracity should be limited only to those cases in which it is safe to assume that patients would want to know the truth. In all other cases it is better to let the physician decide what can be disclosed and to whom it should be disclosed (e.g. a family member instead of the patient).⁵

This consequentialist argument is premised on the assumption that patients do not want to know bad truths. Obviously, people do not have univocal preferences toward truth telling in medicine (Surbone 2004; Surbone et al. 2006). Thus, the claim underpinning the second argument is that, in general, *the majority* of patients do not want to receive bad news. If this were true, then it would be questionable to adopt veracity as clinician’s default attitude. But is this the case? In the last decades researchers have conducted a series empirical studies and qualitative surveys which clearly indicate that now the vast majority of people prefer to know the truth even when it is extremely bad. The data are especially telling for oncology. Increasingly, people express the preference to be told any kind of medical information, including cancer diagnoses. For example In a study of acute ill patient in central Israel, researches found that “most patients did want information about a serious diagnosis: three quarters of the patients studied preferred to be told the truth if they had cancer [78%], and 86% preferred to be told the told of a severe degenerative disease with an adverse prognosis” (Schattner and Tal 2002, 67). These and other studies underscore the global trend of a more favorable attitude toward truth telling in medicine (Surbone 2004).

Thus, although personal and cross-cultural differences may still persist, today it seems that the majority of patients want to be told the truth even when the truth is bad. These studies support the conclusion that doctors withholding or distorting information on the assumption that patients do not want to know them would do more harm than good.

Consequently, it is reasonable for physicians to adopt as a default attitude that of being honest with their patients even in the case of the breaking of bad news.

(1.4.c) Third argument: telling negative truths may harm patients

The third argument is that veracity may harm patients. Receiving a cancer diagnosis may result in severe emotional, psychological and even psychical distress. Accordingly, the third argument holds that clinicians must not disclose the truth because the truth may have severe consequences for patients' health and wellbeing. In these cases, recurring to benevolent deception or concealment is morally acceptable. This argument is similar to the previous one because: it aims at limiting the application of clinician's obligation to veracity to a class of cases, rather than arguing against it; it identifies in this class of with the one of the provision of bad news; and it takes a consequentialist perspective by assuming that in the majority of the cases breaking bad news causes more harm than good to patients.

The main reply to this argument points to the difficulties in predicting future consequences. As Samuel Johnson said "I deny the lawfulness of telling a lie to a sick man for the fear of alarming him [...] you are to tell the truth [...] you are not sure what effects your telling him that he is in danger may have" (Boswell 1997, 89; quoted in Beauchamp and Childress 2009, 289). However, evidence does not support the conclusion that veracity causes more harm than good. Given current attitudes toward truth telling, if the claim that truth-disclosure leads to severe harm in the majority (or a significant number) of patients were true, then we would expect to observe a huge number of these cases.

Despite a few instances in which truth telling may indeed results in severe harm, in the vast majority of the scenarios this seems to be not the case. While the initial shock of receiving

a bad news may produce an intense emotional reaction, these effects tend to fade over the medium and long term. With enough time and support, most of the people seem able to cope even with the most terrible news (Kübler-Ross 1975). Also, the obligations of veracity and to inform patients do not imply that communication should avoid taking the appropriate measures to minimize the negative impact of bad news. Physicians may adopt different techniques to be truthful without incurring in the iatrogenic effects of “truth-dumping”.⁶ For example, truth can be revealed gradually or in staged way.⁷ Moreover, sometimes it is not the sudden confrontation with a bad truth that harms, but the slow and corrosive presence of an ongoing suspicion—as Tolstoy reminds us in *The Death of Ivan Ilych*. Doubting that doctors, nurses and family members are lying about one’s critical clinical condition may be more destructive than being exposed to the truth once every adequate precaution has been taken.⁸

Second, veracity may have positive consequences that outweigh the negative ones. A growing series of empirical and qualitative studies suggests that, despite the initial burden, people who are told the truth have better outputs as for satisfaction, compliance etc. (Surbone 2006). Third, there are other independent reasons for why people may want to know the truth, even when it is bad. In the case of a lethal cancer diagnosis, for example, being told the truth allows patients to come to terms with their condition, to prepare for their death, and to spend some quality-time with their loved ones. These are all legitimate reasons for which people may want to be told the truth regardless of its consequences.⁹

⁶ Bok (1978, xxiii) attributes this term to the psychiatric Will Gaylin, who commented, “Advocates of greater tolerance for lying sometimes ask what the world would be like if we told nothing but the truth without cease. Surely, they ask, judicious lying has to be seen as preferable? To pose the question thus is to assume that we operate, in this world, with only two alternatives: lying or constant, no-holds-barred truth telling. Yet there is something peculiarly wizened and humourless in such a supposition. It leaves no room for discretion, for the ability to discern what is and is not intrusive and injurious while navigating in and between the worlds of personal and shared experience. Part of the learning to deal respectfully with children as with adults is to become aware of all the ways of doing so honestly yet without ‘truth-dumping’”.

⁷ For an account and an example of “staged truth telling” see Beauchamp and Childress (2009, 291).

⁸ Another possible reply may follow the deontological argument for which patients’ right to truthfulness is grounded on a different sort of entitlements related to the respect of their personal dignity and autonomy. We shall return to consider this deontological approach to clinical truth telling in the next chapters.

⁹ In the past doctors used to have a different opinion on this matter. Consider for example what John Gregory (1725-73) said concerning exceptional situations: “it would be very wrong to acquaint the patient that he was really on the point of death, as this would hasten his death so much the sooner, now this may be a very

Therefore, the claim that breaking bad news to patients is likely to cause more harm than good is unfounded. While there are certainly harmful consequences deriving from breaking bad news to patients, it seems that in most of the cases recurring to appropriate techniques of information disclosure can adequately prevent or mitigate irremediable harm. Moreover, the positive consequences of being told the truth may sometimes outweigh the negative ones, while the withholding of the truth may harm in the form of a corrosive suspiciousness. Lastly, there are also compelling non-consequentialist reasons for why patients may prefer to be told the truth. Therefore, unless convincing evidence exists that disclosing bad news causes more harm than good in the majority of the cases, we shall refute the third consequentialist arguments against clinicians' obligation of veracity.

(1.4.d) Fourth argument: lies and deception are always immoral

The analysis of the first three arguments reveals that lies and deception may often do more harm than good. Hence, other things being equal, there are good reasons to maintain that veracity should be clinicians' default attitude in professional contexts. The next logical step is to ask whether lying and deception are justifiable in certain cases or are instead always wrong. The fourth argument takes this latter option, and maintains that lies and deception are immoral without exception. On this view, clinicians' duty of veracity is an absolute duty: clinicians should never deceive or lie to patients.

Invariably, every view supporting a categorical prohibition of lying must deal with a variant of the "murderer at the door" example. Imagine that a murderer—who is looking for a person that you are sheltering in your home—, knock at your front door and asks: "Is X in

important time for to acquaint his friends, as some minutes longer in life, might do a deal of service to the family, therefore a lie in this case may be justifiable" (McCullough 1998, 75, quoted in Jackson 2001, 14).

your house?”. If you endorse a categorical prohibition to lie, then you should answer “Yes”.¹⁰ As a result, your friend will likely be killed. But how can this choice be morally justified? Why should we prefer not to lie in such critical circumstances given the terrible consequences that would ensue?

While it is tempting to refute the fourth argument simply as “unreasonable” and “absurd”, reconstructing its background is important for two reasons. First, it helps to illuminate certain aspects of the morality of lying and deception. Second, it is useful because the claims that are still used to defend the deceptive use of placebos in medicine bear striking similarities with the rhetorical strategies that have been used in the past to qualify the categorical prohibition not to lie in the face of the “murderer at the door” example.

Within the Western tradition, the view that one shall never lie dates back to Biblical times (Bok 1978). The moral problems of lies have occupied generations of theologians because some biblical figures—God included—seem to deceive other to achieve their objectives. How should, then, the ninth commandment “not to lie” be understood? Is there a difference between a lie told to injure someone and one told to save 1000 innocent children?¹¹

¹⁰ Of course, there are other options besides responding to the direct question of the “murderer at the door”. For example one could remain silent, or provide only evasive questions. Kant (1949, 346-50), for example, in defence of his approach, does discuss some of the consequences of telling a lie or the truth at the “murderer at the door example”. For the sake of the argument, I shall not consider these other possibilities here.

¹¹ The following story perfectly exemplifies the kind of examples used in moral philosophy to introduce similar dilemmas: “In a little frame cottage just off Milwaukee Avenue, the Jewish community on Friday knocked a tiny bit off its debt to Zofia Kukla, Chicago’s version of Oscar Schindler [...] During the Holocaust, she hid several Jewish families as Nazi herded Poland’s Jews to the gas chambers of Auschwitz and Treblinka. Her own family, of course, was imperilled by her actions. ‘What I did, I did only because I couldn’t live with the thought that someone else’s death could be on my hands,’ Kukla said. ‘They still come to me in the night, the people I couldn’t save’. When the Nazis occupied Poland during World War II, Jews were rounded up in the rural areas and distributed as slave-labourers to local peasants [...] But in mid-war, having established the extermination camps, the Nazis issued new orders that Jewish farmhands were to be surrendered. Many of Kukla’s neighbours in a tiny village near a city of Bialystok complied, but not Zofia and her husband, Franceszek. At gunpoint, they rescued a Jewish family from Nazis. Other refugees showed up at the Kukla’s small farm, until they were sheltering about a dozen in space hastily dug under the floor of their dairy barn. The Germans suspected as much, and a Polish collaborator brought Nazi troops to Kukla’s house, even as two additional refugees were crouching in the attic. A German officer put a gun at Zofia’s head, but she denied hiding Jews. Then he took a crucifix from the wall and told her to swear upon it. ‘I know it’s a sin to lie upon a cross’, Kukla said. ‘But I know that human life is more important’. [...] several of her guests had died from the privation and disease bred in their cramped quarters. But other survived” (Grossman 1995; quoted in Carson 2010, 86).

St. Augustine's reply to these questions set the standards for centuries. According to St. Augustine, lies are always culpable. By saying one thing while "having in the heart" another, liars subvert the very purpose of language that God donated to mankind. Hence every falsehood is a sin. Yet, not every sin is equally culpable, because some are more culpable than others. Augustine provided an eightfold divisions that ranked lies from those more culpable (lies told in the teaching of religion) to the less culpable (lies that injures not one, and profits someone in saving him from defilement of the body).¹² Lies are all sins, but some are less serious than others, because they are done with a beneficial intention and have beneficial effects.

Under this view, however, lying to the murderer at the door would still be a sin. As such, it must be avoided and it can never be excused or recommended. To circumvent this conclusion, in the following centuries three strategies have been attempted to further qualify St. Augustine's theory.¹³ The first, proposed by Aquinas in the *Summa Theologica*, has been that of allowing for a class of lies to be pardonable. Building on Augustine eightfold distinction, Aquinas distinguished three kinds of lies: the *officious* lies, which are told to save someone from injury; the *jocose* lies, which are told in jests; and the *mischievous* lies, which are told to hurt someone. According to Aquinas, only the latter kind cannot be pardoned. The interpretation of this doctrine has led to further controversies: once the categorical ban is removed, it has been argued, there is no way of stopping lies from spreading.¹⁴

¹² St. Augustine's complete classification of lies is as follows: (i) lies told in teaching religion; (ii) lies which hurt someone and help nobody; (iii) lies which hurt someone but benefit someone else; (iv) lies told for the pleasure of deceiving someone; (v) lies told to please others in conversation; (vi) lies which hurt nobody and benefit someone; (vii) lies which hurt nobody and benefit someone by keeping open the possibility of their repentance; (viii) lies which hurt nobody and protect a person from physical 'defilement' (St. Augustine 1952).

¹³ In reconstructing the history of this argument I follow the excellent account provided by Bok (1978). However, I disagree with her on the way in which we shall reply to Kant's argument. While she maintains that Kant's argument should be rejected because it leads to unsound conclusions, or because it has never been advocated without further qualifications, I think that it is possible to reply by taking seriously the challenge of the categorical imperative, hence arguing that a world in which the procedural methodology that I will defend is thought as a universal maxim of conduct is not necessarily contradictory; see chapter 5.

¹⁴ In a letter to Cosentius, St. Augustine noted, "little by little and bit by bit this evil will grow and by gradual accessions will slowly increase until it becomes such a mass of wicked lies that it will be utterly impossible to find any means of resisting such a plague grown to huge proportions through small additions. Hence it has been most providentially written: 'He that contemneth small things, shall fall by little and little'" (included in Bok 1978, 254).

The second strategy was the one of “mental reservations”. St. Augustine’s defined a lie as the telling of something while having something else in one’s heart. This definition is based on the difference between what is stated and what is known.¹⁵ One can state things in speech as well as in thought. However, this difference matters only for humans: God knows everything and thus for Him it is irrelevant whether one states a falsity in words or thought. Accordingly, one can avoid lying to God by “adding” a proper qualification in his own mind to what he has just said. In the middle age, these techniques of “mental reservation” were used to take oaths or in court, where people swore on God’s name and expected to be punished if they had lied. But “mental reservations” can be used also medicine: if a patient with a cancer diagnosis asks, “Doc, are my lab tests normal?”, a doctor can confidently reply, “Yes, it is everything OK” and then add in his own mind the mental reservation “... for a patient who has your type of cancer”. As noted by Bok, and however strange it may sound, as late as in 1968, a Catholic book of medical ethics still recommended the practice of mental reservations to complement the use of benevolent deception (1978).

A third strategy to qualify the categorical prohibition of lying was the one advocated, among others, by Grotius. Grotius defined a lie as a falsehood told to someone who has a legitimate right to the truth.¹⁶ On this view, a falsehood is not morally culpable whenever it is told to someone who has not such a right. In fact, not everyone has a right to the truth: one can lose it because he has harmful intentions toward others (the murderer in the example); because it is socially agreed that he has no such right (e.g. children or insane persons); or because he has voluntarily waived it, as in the case of two persons contracting at the market. According to this view, it could be moral to say a falsehood to a murderer in the example. In fact, because of his bad intentions, in these circumstances the murdered has no right to truthfulness, and so one could say a falsehood without saying a lie.

¹⁵ St. Augustine, in his essay “Against Lying”, however, defines a lie as a falsehood told with the intent to deceive; see St. Augustine (1952).

¹⁶ Grotius did not speak of a “right to truth” but of a right to “the liberty of judgment”, i.e. to expect from other truthful communication as to being able to decide. See Hugo Grotius (1952, chapter 1).

After Grotius, Immanuel Kant heavily influenced the debate on the morality of lies. Criticizing the view advanced by the French philosopher Benjamin Constant—which was similar to Grotius’s—, Kant objected that “truth is not a possession the right to which can be granted to one and denied to another [...] the duty of truthfulness [...] makes no distinction between persons to whom one has a duty and to whom one can exempt himself from this duty; rather, it is an unconditional duty which holds in all circumstances” (Kant 1949, 249). According to Kant, “by a lie a man throws away and, as it were, annihilates his dignity as a man” (Kant 1949). Like St. Augustine, Kant’s viewed lies as always culpable. Differently from St. Augustine, however, Kant does not distinguish between lies that are less culpable than others. Irrespectively from their consequences, on Kant’s deontological view “Truthfulness is statements which cannot be avoided is the formal duty of an individual to everyone, however great may be the disadvantage accruing to himself or to another” (Kant 1949, 254).

By saying that “truthfulness is a formal duty” Kant meant two things. The first is that such duty can potentially be generalized without contradiction as a universal maxim of conduct. Following O’Neill’s (2002) interpretation of Kant’s categorical imperative, this is tantamount to image a world in which everyone tells always the truth, and asking whether this world can be imagined without logical contradiction.¹⁷ Though only a few would desire to live in a world where everyone always tells the truth, this does not lead into contradiction.¹⁸

Of course, always telling the truth would lead to many consequences, but there seems to be nothing logically wrong in hypothesizing a world where everyone is honest.

¹⁷ Kant gave several different formulations of the categorical imperative (CI). The second formulation of the CI is that “we should not treat others just as means in themselves and not as ends” is equally famous, and influential, as the first. It should be noted, however, that Kant never said that we should never treat others like means, but only that we should never treat them *only* as means. The difference is crucial. For saying that we should treat other only as means implies that, to some extent, it is possible to see other as means to achieve our ends. For example, if you are waiting at the postal service for retiring a package, the person who would handle you that package is for you a “means” to achieve your goal (retiring the package). What we should not do in any case on Kant’s view, is to consider this person just a means and not *also* as an ends in her/himself; for only in this latter case we would not be dealing with a person at all. For a similar perspective see Jackson (2001) and Carson (2010).

¹⁸ It should be noted that Kant does distinguish between a duty not to lie and a duty to tell everything. For example, while he argued that all lies are morally wrong, he was not against the keeping of secrets, on which he noted “No man in his true senses ... is candid” (1979, 224, quoted in Jackson 2001, 46).

Contrariwise, imagine a world in which everyone lies. Since lies are told to gain some sort of advantage and control over others, in order to be effective they require the trust of others. Like parasites, lies can thrive only at the expenses of a trusting host. But if everybody lies all the time, then nobody will eventually trust anyone. And without trust, no lie can be believed. Hence, to elevate lying at the level of a general maxim of conduct is a self-defeating endeavor. Consequently, telling lies and deceiving others should not be part of our morality. In fact—and this is the second element—on Kant’s view every moral obligation is absolute. There cannot be a conflict of duties, because duties that pass the test of the categorical imperative cannot conflict with one another. Accordingly, “to be truthful (honest) in all declarations [...] is a sacred and absolutely commanding decree of reason, limited by no expediency” (Kant 1949).

Kant’s argument provides the most powerful case for the categorical ban of all lies (and deceptive practices) in the history of moral philosophy. It has the merit of underscoring how unpleasant would be to live in a world where everyone is always ready to lie whenever the odds are in her favor. Certainly such world would not provide an ideal environment for medicine as a practice meant not only to foster patients’ health but also to respect their autonomy and dignity. It also empathizes the central role trust plays in everyday life and medicine, and how lies and deception might easily and irremediably jeopardize it. However, whenever it is taken in its original formulation, Kant’s deontological view is problematic, almost impossible to live by, and rarely (if ever) advocated as a sound perspective to be adopted in medical ethics without qualifications.¹⁹

¹⁹ I am not aware of anyone who is defending Kant’s approach on lying in contemporary ethics. There are, however, a few authors who have tried to elaborate a Kantian view which, in principle, can be applied also to biomedical contexts. For example, Korsgaard (1996) proposes an elaboration of Kant’s position according to which we should never lie without exception, because otherwise we would be treating others as pure means to our ends, rather than as ends in themselves. However, she argues that such duty holds just in “ideal situations”. When instead we are facing a “non-ideal situation”—e.g. if we are confronting something like the “murderer at the door”—then we can depart from this rule only insofar as doing so would restore the ideal conditions (for a criticism of this “double level theory” see Jackson 2001, 60-64). Notice how this position represents another way—“a Kantian way” indeed—of qualifying an absolute prohibition to avoid its counterintuitive consequences.

In particular, the view that our duty to veracity should be absolute, contrasts with our current understanding of the goals of medicine and of medical ethics. Today we care *both* for the health of patients *and* for their dignity and autonomy as persons. For the greatest part of the history of medicine veracity has been considered entirely subordinate to beneficence. With the rise of autonomy, as we have seen, veracity has come to be recognized as a fundamental requisite of doctor-patient communications. However, this does not imply that the primary end of medicine has become that of fulfilling an obligation of veracity. Rather than replacing the obligation of beneficence with the one of veracity, the contemporary understanding of medical ethics is that the latter view ought to be considered as an expansion of the former one. The resulting plurality of duties inevitably leads to moral dilemmas. Taking the duty of veracity as absolute leads to counter-intuitive cases, which do not fit with our intuitive view of the goals of medicine. Consider the following example:

He was 90 years old. As a young man he had been decorated for courage in battle, but as he got older his great fear was that he might one day develop cancer

[...] A biopsy specimen of an ulcer on his lip confirmed squamous cell carcinoma. No need for surgery or admission to hospital. After a short course of radiotherapy it would heal, and probably never cause him any further trouble. "It's not cancer, is it?", he asked, his eyes moist with tears. And emphatically, without the slightest hesitation or qualification (which would have been fatal to effective reassurance), I assured him that it was not. Was this a blatant, but some would say justifiable, lie? On the contrary, was it not the truth? He had what the medical profession calls cancer. He did not have what he meant by cancer. He did not have a shameful, painful, fatal disease that would soon spread. Or anything like it. For him it was more truthful to say that it was not cancer than it would have been to say that it was.

I do not believe that anyone, no matter how good a communicator and no matter how much time spent over it, could have told this man that it was cancer, but curable, without leaving him with a false impression. Would it not have been somewhat foolish and arrogant to have attempted, at this stage in this man's life, to change his long-held view of what was meant by the word? Speaking to him in his own language (a mark of respect, not of paternalism) he did not have what he had always dreaded. He was not being shielded from the truth. He was being given the truth. Does firm, unhesitating, pragmatic common sense of this kind still have a place in medical practice? Or is it now becoming impossible given the current, rather rigid, unimaginative, time consuming, and sometimes self-defeating attempts to explain everything to everybody? (Brewin 1994: 1512).

Siding with the author, I maintain that the use of a lie or concealment in this case is ethically justifiable. In this situation, an absolute duty to veracity leads to an inhuman idea of medicine, one for which the respect to one's duty is more important than caring for vulnerable people. There are situations in which clinician's duty to beneficence should

override those of veracity. The crux of any account of the ethics of veracity in medicine is, of course, that of explaining why these cases are justifiable exceptions, and how can they be distinguished from other cases that are not. In order to clear this point, we need to look closer at why lying and deception are morally problematic in everyday life and in medicine.

(1.3) Ross's concept of *prima facie* duty

According to what we have seen so far, it is reasonable to hold that clinicians should adopt as their default attitude veracity rather than duplicity. Usually, in today medical ethics, this idea is further specified in the view that clinicians have a *prima facie* obligation of veracity (Beauchamp and Childress 2009; Carson 2010; Jackson 2001). This view is heavily informed by Ross's proposal—advanced in his classical *The Right and the Good*—to distinguish between *prima facie* and actual duties. A *prima facie* duty is an obligation that must be fulfilled unless it conflicts, on a particular occasion, with an equal or stronger obligation (Beauchamp and Childress 2009, 15; Ross 1930; Ross 1939).²⁰ Thus, to say that clinicians have a *prima facie* obligation of veracity entails that, others things being equal, honesty and truthfulness are always to be preferred to lying, deception and malicious concealment.

This obligation, however, is not absolute because in some cases different *prima facie* obligations might legitimately conflict. For example, in the case of a police officer inquiring about a patient, the *prima facie* duty of veracity may conflict with *prima facie* duty of protecting patients' privacy. In these cases it arises a moral dilemma, and the series of reasons supporting each conflicting duty have to be specified and balanced one against the other to decide which one prevail in these circumstances (Beauchamp and Childress 2009). In these cases, Ross

²⁰ In *The Right and the Good*, Ross states, "I suggest '*prima facie* duty' or 'conditional duty' as a brief way of referring to the characteristic (quite distinct from that of being a duty proper) which an act as, in virtue of being of a certain kind (e.g. the keeping of a promise), of being an act which would be a duty proper if it were not at the same time of another kind which is morally significant" (1930, 19-20).

stated that we have to determine our *actual* duty or obligation. Actual duties or obligations are those duties and obligations that we ought to perform after all things have been considered.

Throughout this dissertation I shall argue in favor of the view that clinicians have a *prima facie* duty of veracity. On this view, deception can be justifiable in exceptional cases. While this position is almost uncontroversial, there exists considerable debate on how it ought to be specified.²¹ For example, one may disagree on what counts as “deception” or “lying”; on why dishonesty in medicine is morally blameworthy; on how exceptions can be distinguished from the cases in which an obligation to veracity should be morally binding; and on how such exceptions ought to be justified.

(1.4) Veracity as a *prima facie* duty

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 too general and keeps implicit the relationship between the obligation of telling the truth and the obligation of providing necessary information to patients.

To reach a better definition, let us start by noting how the general commandment “Tell the truth!” is ambiguous and can be understood in two different senses (Bok 1978;

²¹ Not everyone agrees that clinicians have a *prima facie* duty of veracity. For example, Jackson (2001) takes a very different view, maintaining that doctors have an absolute duty not to lie, but that they have no duty, no even of a *prima facie* nature, not to conceal and deceive. Her argument is premised on a broad definition of deception that includes all practices finalized at instilling in others false beliefs, including some trivial and socially acceptable ones as make-up or clothes that make us look slimmer. Consequently, she argue, it is unrealistic to claim that all these cases should be seen as exceptions to some *prima facie* rule. I find this perspective unconvincing and eventually confusing if applied to medicine. In fact, it is clear that we do not count s culturally accepted practices like wearing make-up as instances of morally problematic deception, and that they are “deceptive” in a sort of indirect or very trivial way. At the same time, we count most other cases of deception, for example the provision of deceptive placebos in medical settings, as being ethically problematic. By allowing every kind of deception to be intrinsically unproblematic, Jackson’s view has the undesirable consequence of blurring the moral issues associated with this latter category of cases. For a more detailed response to this view, see (4 4).

Jackson 2001). In the first sense, it can be understood as meaning: “Do not lie!”; that is, as a negative obligation of not telling falsehoods. In the second sense, instead, it can be understood as meaning: “Tell the truth!”; that is, as a positive obligation to disclose information. 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.

These two complementary obligations can and should be distinguished. In fact, health professionals do not have an obligation of “complete candor” or “absolute disclosure”. Clinicians must disclose to patients only the information relevant to respect their autonomy and to achieve a valid informed consent. Accordingly, I shall henceforth distinguish between two complementary *prima facie* obligations: the “duty of truthfulness” and “duty to inform”.²²

The *prima facie* negative obligation of “truthfulness” implies that, other things being equal, clinicians must refrain from lying and deceiving. On this view, lying and deceiving are both ways of violating the obligation of truthfulness, and thus of violating the more general obligation of veracity. The *prima facie* positive obligation of “the duty to inform” patients, instead, implies that, other things being equal, clinicians must disclose all the relevant information required for respecting patients’ autonomy and to achieve a valid informed consent. On this view, the duty to inform is thus conceptualized as a narrower specification of the general principle of respect for patients’ autonomy (Jackson 2001; Beauchamp and Childress 2009; Beauchamp 2010; see chapter 3).

²² On this distinction see also Jackson (2001) and Carson (2010). Carson proposes a similar distinction by distinguishing between “negative honesty” and “positive honesty”.

To sum up, in what follows, I shall conceptualize clinicians' duty to veracity as a *prima facie* duty composed of two other *prima facie* duties: the negative obligation of "truthfulness" and the positive obligation of "informing patients" by providing all the relevant information.

(1) Summary

In this chapter I have discussed four classical arguments against clinicians' obligation to veracity in medicine, concluding that they are all wanting. It is not the case, since the "whole truth" cannot be known, communicated and understood, that physicians should always act paternalistically and decide what ought to be disclosed to patients. Also, there are good reasons to think that today the majority of people prefer veracity to benevolent deception, and that people receiving an honest disclosure of medical information are generally better off than those that are left in the dark—even in the case of bad news such as a cancer diagnosis. Hence the two consequentialist arguments aimed at limiting the scope of the obligation of veracity fail. Finally, Kant's deontological ban of all lies is problematic because clinicians do confront genuine moral dilemmas with conflicting duties. Hence, while there are good reasons to support the idea that clinicians have a duty to veracity, it seems also that under particular circumstances we should allow for qualified exceptions. I have then proposed to conceptualize clinician's duty of veracity as a *prima facie* obligation, arguing that this obligation can be further specified as the conjunction of two more specific *prima facie* duties: the negative obligation of truthfulness, and the positive obligation to inform patients.

2. Lying, Deception and Concealment

Half a truth is often a great lie.
Benjamin Franklin

(2) Introduction

This chapter explores different ways in which clinicians can violate their *prima facie* duty of veracity. Section (2.1) introduces and distinguishes between three general ways in which someone may be dishonest in communication by (a) deceiving; (b) lying; (c) and keeping someone in the dark by interfering, withholding, concealing relevant information, or telling half-truths. Section (2.2) discusses how different forms of dishonesty may often lay on a practical continuum; then section (2.3) discusses whether these different ways of being dishonest have intrinsically different moral weights.

(2.1) How to be dishonest in professional communication

After distinguishing between the duty of truthfulness and the duty to inform patients we are in a better position to understand what the duty of veracity entails in clinical contexts. The next logical step is to look at the ways in which clinicians may fail to respect this *prima facie* duty. When and how can doctors be dishonest in professional communication? Answering this question is not trivial, in part because the *prima facie* “duty to inform” entails that it is possible to violate the duty of veracity without lying and deceiving. As I will show, there are ways in which one can intentionally be dishonest without stating any falsehood or without instilling/failing to remove a false belief in others. To unpack this important claim, in this section we shall focus on defying the concepts of (a) deception; (b) lying; (c) and keeping someone in the dark by interfering, withhold, concealing information, and telling “half-truths”.

(2.1.a) Two ways of violating the duty of truthfulness

A minimal requirement for any theory of veracity is that of defining the concepts of “lying” and “deception”. This is not an easy task: lies and deception are ubiquitous in our private and public life, and they are often intermingled (Bok 1978). They also come in many forms. Indeed, the moral landscape of lies and deceit is ample and variegated. Accordingly, scholars have proposed several ways of conceptualizing “lying” and “deception”. However, two general 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.

(2.1.b) Distinguishing deception from the provision of false information

The first relevant distinction is between deception and the provision of false information. There is a wide consensus that deception can be generally 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 1878). 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 your assignment on time. Suddenly, the professor asks you “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

your professor because you are intentionally reporting a wrong timing in order to instil a false belief into 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 instil a false belief into the professor’s mind. However, this time you would not be deceiving the professor, as you have no intention of instilling a false belief, but only providing a false information.

On this account, thus, every deceptive act implies three logical subjects: a deceiver (S), a deceived (S1), and a belief (X) that the deceived comes to entertain because of the intentional behaviour 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. 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 ticket. 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).²³ 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.

(2.1.c) Distinguishing deception from lying

The second cardinal distinction is between lying and deceiving. Following the previous definition, it is possible to deceive others in different ways through disguise, body language, speech, and even by remaining silent. What is important is to act “on the intention of mislead

²³ This example is adapted from Gold and Lichtenberg (2014), see note 28.

someone”, not the means whereby we achieve 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);²⁴ (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 of verbal or written signs (Bok 1978; Chisholm and Feehan 1977).²⁵ So, if you just think of replying “5.50” to the professor in the example in order to finish your exam, but then you say nothing, then you would not have lied because you have not stated anything.

But imagine a clinician who prescribes a placebo to a patient under the name of “extract of falsissima credulonis”. If the patient asks to 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 instil 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

²⁴ The view that lies need to be false statements is problematic in the face of statements that are known by the liar to be false, but that in fact are true. Consider the case in which you answer to the murderer at the door “I saw Fred running into the woods”. By saying so you intend to save Fred who is hiding in your home. However, fearing to be discovered, Fred has left his hideout and without warning you has really headed toward the near woods. As a consequence, your statement was true and it was not, technically, a lie. This objection is easily overcome by those views for which a lie entails the “intent to deceive”. However, it is more problematic for the view proposed by Carson (2010), according to which lies do not require the intent to deceive, but the intent to warrant the truth of what one is saying. On a possible reply to this objection see Carson (2010, 42).

²⁵ This is not, however, the only way in which one can understand the meaning of the term “lie”. Another option is to define every act of deception a “lies”. This is, for example, the position of Ludwig, who defines a lie as “any type of behaviour that deviates from the truth” (1965, 4, quoted in Jackson 2001, 43). This broad view has the defects of obscuring the fact that, other things being equal, we tend to assign different moral weights to lies and to deceptive practices. Similarly, Ekman uses the two concepts as synonymous, as he defines a lie as “one person intends to mislead another, doing so deliberately, without prior notification of this purpose, and without having been explicitly asked to do so by the target” (1985, 28; quoted in Jackson 2001, 43). According to Ekman, even the concealment of one owns emotion amount to an act of “lying”. Again, this is a too broad definition, as we do not usually associate the attitude of being a reserved or introvert person with the character of being a liar.

intention to deceive others. Carson (2010, 20) 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 to preserving my life. Giving false testimony is necessary to save my life, but deceiving other is not; the deception is merely unintended “side effect”.

This example demonstrates that the usual “dictionary” definition of a lie as “any intentional deceptive statement which is stated” (Bok 1978; Chisholm and Feehan 1977; Jackson 2001) do not cover all the relevant cases.²⁶ 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 (2010, 39) 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 S1.²⁷

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 to the basic contract between speakers according to which veracity is the default attitude in communication. This implicit requirement may, in certain contexts, become

²⁶ For example, Jackson (2001, 48) defines a “lie” as “the asserting of what one believes to be false in order to deceive someone”.

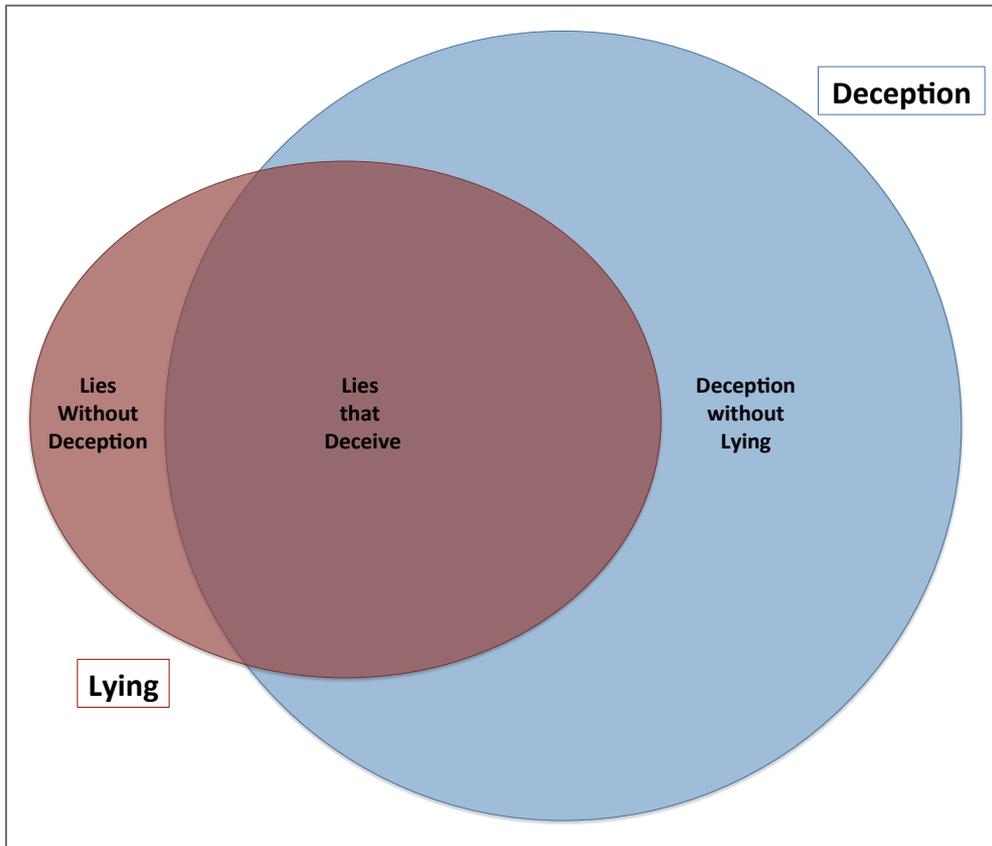
²⁷ Carson gives several other definitions in his elaborated account; see Carson (2010), chapter 1.

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 told us a lie we feel betrayed.

In the rest of this dissertation I shall maintain that 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 without using words, for example through messages in Morse code.²⁸ Likewise, suppose that, after completing a lobectomy, a surgeon realizes that she has operated the wrong lung. Suddenly, the patient wakes up and asks, “Doc was everything Ok?”. If the surgeon nods empathically and smile, then she would deceive the patient. If, instead, she replies, “Yes, everything was just fine” then she would lie. Second, deception always requires the “intention to deceive”, while lies can be used also to accomplish different performative functions.²⁹ However, it is important to underscore that lies without the intention to deceive are just borderline cases, and that normally lies are told with the clear intent of deceiving others. The following diagram depicts what has been said so far:

²⁸ On the possibility of using language to deceive other without lying, consider the following example by Gold and Lichtenberg (2104, 220) “It is 20:55; I am rushing with a friend of mine towards the cinema to purchase the last two tickets for tonight’s last show. We were earlier surprised to find out that tonight, as an exception, the last show will start at 21:00 instead of the usual 20:00. In front of us in the elevator, we meet a couple planning to see the same movie. We know that if they arrive at the box office before us and purchase the last two tickets, we will miss the movie. But they turn to us and ask if we know when the last showing of the movie begins. My friend replies: ‘Usually the last showing starts at 20:00’. They thank us politely and leave the elevator at a different floor. My friend winks at me while trying to conceal his satisfaction. Was my friend lying? We think not, since he did not provide any false information. The statement ‘Usually the last showing starts at 20:00’ is true. However, he was certainly deceptive, since he intentionally and successfully caused our competitors for tickets to believe that the movie started at 20:00. Indeed, only by inserting this false belief into the couple’s minds were we able to achieve our goal—purchasing the last two tickets”.

²⁹ 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.



(2.1.d) Four ways of violating the duty to inform

Using lies and deception in medical settings violates clinician’s negative obligation of truthfulness. However, the obligation of veracity entails also “the duty to inform patients”. Hence, it is possible to be dishonest—contravening to the duty of veracity—without violating the obligation of truthfulness. This claim, however, requires further qualifications: How is it possible to be dishonest without lying and deceiving others? Following Carson (2010), we shall now consider four related ways in which it is possible to violates the duty of veracity without necessarily violate the duty of truthfulness; they are: (i) keeping someone in the dark by distraction; (ii) keeping someone in the dark by withholding information; (iii) keeping someone in the dark by concealing information; (iv) telling “half-truths”.

(2.1.e) “Keeping someone in the dark” by malicious concealing

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 in which someone can achieve this objective which, in part following Carson (2010), I shall generally label henceforth as “keeping someone in the dark” about something X.³⁰ We shall now consider three 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 s/he holds as 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 enrol 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 considerably 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 read carefully these details you might reconsider your participation.

Hence, in order to distract your attention, I start with you a conversation about other topics, for example your favourite holidays 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

³⁰ 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.

belief that clinical trials are risky, thought this belief is vague and not well circumstantiated. To act in this way violates the duty to inform participants in clinical research—i.e. a failure to respect the duty to inform. In this case my conduct is dishonest, and yet I have not acted as to instil in you a *false* belief, or to make you retain a false belief that you already had.³¹ 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 prevent S1 to learn the truth about X. Image that we are in the same scenario, but this time I am not disturbing you in any way 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 constrains. Again, fearing that you might not want to proceed upon learning this news, I decide not to disclose you what I know about the new study. This time I am not preventing you from understanding information that is already available to you, 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 always risky”, I am not instilling in you a false believe or failing to correct one. Yet, my conduct is clearly in contrast with my obligation to inform you in a way adequate to respect your autonomy and right to inform consent.

A third way in which someone S may prevent S1 from learning the truth about X is when S actively conceals some information about X to S1. Recall again the same scenario, but a few days later. Following the recommendations of the ethical committee, the module has been updated as to list among the possible side effects those discovered by the recently published study. However, since I think that the language in which they have been described

³¹ This example has been adapted from Carson (2010).

is too scary, unbalanced and might frighten possible participants, before printing the module I delete some parts of the description of the newly discovered side effect. This time I am neither just interfering with your understanding of the available information about X, nor I am just withholding information about X, but I have instead intentionally done something as to hide from you information about X. Also in this case I will clearly violate my obligation to provide you comprehensive and adequate information about the treatment that you are about to receive as part of the trial, but technically I am neither deceiving nor lying to you.

These three 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 *prima facie* duty to adequately inform 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 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”, hence distorting the way in which you could interpret or understand some information about X. Imagine that I am willing to prescribe you a certain “natural treatment” that I invented. In constructing my case, I introduce in my disclosure procedure vague references to the efforts of Big Pharma to silence all studies on the efficacy of natural, readily available products. While in the right context these claims may not be false, by using them in this particular context I clearly intend to put a “spin” in my story, presenting my “natural”

remedy as a powerful product publicly unknown because of the efforts of big corporations. Despite 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 this time 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.

(2.2) Deception, lies, concealment and the “spill over problem”

Distinguishing between different ways in which we can be dishonest in communication is important because we tend to attribute to them different moral weights (see next section). However, it also important to underscore that in practice people engaging in dishonest communication usually resort to more than one technique. Dishonest communication often occurs in a continuum of more or less explicit deceptive behaviours. Consider the infamous case of the Tuskegee syphilis study. This well-know example of medical abuse was possible only because the participants were not informed of being part of a scientific study for which they would have not received already available effective medications (Jones 2008). But in order to run the experiment, the various health-professionals had to recur to something more than a simple lie. Rather, during the decades in which the study was conducted, they had to set up a complex system where lies, deception, concealment, withholding of information, half-truths, etc. were all necessary and functional tools to pursue their agenda.

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 “spill over problem” is the one of a physician deceptively prescribing an impure placebo—e.g., an antibiotic for a viral infection (see chapter 6). Since this is a “real”

medicine, in presenting it to the patient an open lie is not required: a vaguely deceptive description will suffice. However, if the patient asks the direct question, “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” the previous lies. The more lies will be told, the more lies will be needed. As noted by Bok, “the first lie must be thatched with another or it will rain through” (1978, 25). Thus, while it is useful to distinguish between lies and deception from a technical point of view, it should be stressed that in real cases lies, deception, selective concealment and other practices of dishonest communication often occur and thrive together, easily spilling one into the other.

(2.3) Are lies more culpable than other forms of deception?

Dishonesty in professional communication can take different forms to violate the *prima facie* duty of veracity. Some of them require stating something with an intention to deceive; others require instead simply omitting some information. But do different dishonest practices have also different moral weights? Is the stating of an open lie more culpable than the intentional withholding of relevant information?

Scholars have endorsed different views concerning this issue. The prevalent position is that, other things being equal, lies are in general more blameworthy than other deceptive techniques.³² This “gradualist” position has been defended, among others, by Beauchamp and Childress (2009, 289), who write, “deception that does not involve lying is usually less difficult

³² Jackson (1991) has defended the view that we should sharply distinguish between lies and deception: “while doctors generally speaking should no truck with lying, deliberate deception need not in general pose a significant threat to trust”; I strongly disagree with this position for reasons that I explain in (4.2).

to justify than lying, in part because in many contexts in health care it does not threaten as deeply the relationship of trust [...] Underdisclosure and nondisclosure of information are usually still less difficult to justify”.

The view that lies are more blameworthy than other dishonest practices fits well with the adopted definition of a lie as a false statement of which we “intend to warrant the truth”. In fact, since lies always require a statement, lying always entails an explicit commitment to warrant the truth of what we are saying. Comparatively, this commitment is certainly less explicit when we engage in other deceptive practices like the concealment of relevant information. This would explain why lies are generally perceived as more difficult to be justified: because of our public commitment in upholding their truth, lies corresponds also to an explicit request of trust by other persons. And the more trust we place in others, the greater is the negative impact if we discover that we have been betrayed.

However, while this view may hold in general, it should not be taken without qualifications. First, because of the “spill over problem” even a trivial act of deception can easily lead into an open lie. Second, in certain situations omitting one piece of information may damage autonomy and trust just as much as the stating of open lie. Likewise, an open lie can instead be easily pardoned depending on the specific circumstances. Imagine that your clinicians, upon being improperly questioned by your elderly mother about his personal life, answers, “Oh, it is everything OK”. Yet, you know that recently he got divorced. He just stated an open lie, but it is hard to see how such a lie would irremediably damage our trust in his therapeutic competences and moral integrity. Dishonesty is always context and audience-sensitive. Therefore, though in general it is easier to pardon a vague deception than an openly stated lie, often the two go hand in hand, and depending on the particular circumstances the former can be more harmful and blameworthy than the other.

(2) Summary

In this chapter I have distinguished different ways in which clinicians can violate the *prima facie* duty of veracity through deception, lying, keeping someone in the dark, and telling half-truths. It is possible to be dishonest without stating a lie or technically deceiving someone. However, despite these analytical distinctions, in practice it is often hard to sharply separate one act of dishonesty from another, as they easily tend to “spill” one into the other. Furthermore, the relative moral weight of an act of deception, concealment and lying is always situational: normally lies are more difficult to justify than deception and concealment, but in many contexts the reverse may instead hold true.

3. Deception, Autonomy and Trust

Whatever matters to human beings, trust is the atmosphere in which it thrives.

Sissela Bok

If truth is the first casualty, trust is the second.

Roger Higgs

A liar should have a good memory.

Quintilian

(3) Introduction

This chapter inquires into the reasons why deception is *prima facie* wrong in clinical contexts. The view that I will defend is that clinical deception is *prima facie* wrong because it threatens the fiduciary pact between doctor and patient, which is also a precondition for respecting patients' autonomy and for constructing a positive therapeutic relationship. We shall begin by analyzing two arguments that have been used to maintain that deception in medicine is morally problematic because it disrespects patients' autonomy and because it threatens the bond of trust between patients and clinicians. Then, we shall clarify the relationship between the preservation of trust and the respect of patients' autonomy. Finally, we shall introduce and discuss the moral phenomenon of the "discrepancy of the perspectives".

(3.1) Deception in clinical medicine

The view that clinicians have a *prima facie* duty of veracity is grounded on the recognition that there exists an initial imbalance between truthfulness and falsehood: other things being equal, we should always prefer the former to the latter. But why is falsehood less desirable than truthfulness as a default attitude? Why are lies, deception, and other dishonest practices more worrisome than truth telling and veracity? Why are dishonest clinicians morally blameworthy?

Answering these questions is important not only to understand why we should avoid duplicity in medicine, but also to shed light on the implications that might follow from condoning exceptions to the duty of veracity. Scholars in medical ethics have identified two main arguments supporting the view that clinicians' dishonesty is *prima facie* wrong: the first concerns the infringement of patients autonomy; the second the breaching of patients trust. As the following schema depicts, both arguments moves from diverse premises, but they share the same conclusion

- Clinicians must respect patient' autonomy
- Deception disrespects patients' autonomy
- Clinicians must preserve patients' trust
- Deception threatens patients' trust

Clinicians should not deceive patients

Before analyzing these arguments in more details, however, two clarifications are in order.³³ First, there are more than two arguments that can be used to defend the view that clinicians should be honest in their professional communication. Other possible arguments, for example, may conclude that dishonesty ought to be avoided in medical contexts because of economic or legal reasons, or simply because it corrupts the character of those practicing it. These other possibilities notwithstanding, in this chapter I shall focus only on the two above arguments because they are the most relevant ones from a moral point of view and for the contemporary debate in medical ethics.

Secondly, “autonomy” and “trust” are magmatic concepts that resist univocal (and clear) definitions. As we shall also see in the next sections, different authors have defended significantly different views of how we should conceptualize clinicians’ duty of respecting patients’ autonomy, of how clinicians could preserve patients’ trust, and accordingly of how the morality of clinical deception ought to be conceptualized. Clearly, depending on the meaning assigned to the terms “autonomy”, “trust” and “deception” it is possible to interpret the above arguments in different ways, or to agree with them but then to draw entirely different inferences as to what we ought to do in the face of moral dilemmas involving clinical deception.³⁴ In this respect, the limited aim of this chapter is only that of discussing a distinct set of argumentations that are at the core of the present debate in medical ethics.

³³ Following the view that I have adopted throughout this dissertation, all duties in this schema (of respect for autonomy, of preserving trust, and of not deceiving—i.e. of veracity) have to be understood as *prima facie* duties.

³⁴ For example, the conception of “relational autonomy” proposed by some feminists (Ells 2001; McLeod and Sherwin 2000) is only partially represented in what I will discuss in this chapter. Similarly, Rawlinson (1985) has defended a view for which each disease impairs patients’ autonomy to some extent and therefore it is sometimes permissible for doctors to deceive patients if this would conceivably restore their long-term autonomy.

(3.1.a) Deception and the principle of respect for autonomy

The first argument deals with the principle of respect for autonomy and is grounded in the claim that dishonesty impairs patients' autonomous agency:

Respect for Autonomy

- (i) Clinicians must respect patients' autonomy
- (ii) Deception disrespects patients' autonomy

Clinicians should not deceive patients

Autonomy is one of the key notions in contemporary law, politics, and philosophy, and it “is almost certainly the most important value ‘discovered’ in medical and research ethics” in the last forty years (Beauchamp and Faden 1986, 18). While autonomy is not a monolithic concept, the dominant perspective in biomedical ethics conceives it as encompassing “self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice” (Beauchamp and Childress 2009, 99). The concept of autonomy is usually clarified with a reference to Greek city-states: an agent is autonomous if she acts according to a self-chosen plan just like an independent government establishes its confines and sets its policies. Today respecting patients' autonomy is an acquired value in medicine, and especially in Western industrialized contexts (Beauchamp and Childress 2009; Asai and Kadooka 2013; Surbone 2006).³⁵ Accordingly, in these contexts, premise (i) is considered uncontroversial.

³⁵ An important issue here regards the relation between dishonesty and patients' right to informed consent. In this chapter I will not address this issue directly, as I will instead focus more on the principle of respecting patients' autonomy. However, since the patients' right to informed consent is usually grounded on the principle of respect for autonomy, from a moral point of view, the latter issue can be seen as a specification of the former. There are other reasons that support the practice of informed consent, and other scholars—such as Onora O'Neill—have proposed to ground informed consent in other theoretical principles rather than the (sole) principle of respect for individual autonomy. On the relationship between informed consent and the principle of autonomy see (Beauchamp and Childress 2009); on O'Neill critique see O'Neill (2002); on a possible reply to these positions see Beauchamp (2010); for a detailed analysis of the position that trust provides a better starting concept than autonomy to ground informed consent see, instead, Eyal (2012).

Premise (ii) requires instead more clarification. In what sense can deception disrespect patients' autonomy? To answer this question it is useful to note that, similarly to the principle of veracity, also the principle of respect for autonomy can be stated as the conjunction of a negative and of a positive obligation (Beauchamp and Childress 2009, 100). As a negative obligation, clinicians have a duty not to infringe on patients' *liberty*, that is, on their ability to act free from external constraints. In this respect, a paradigmatic example is that of a Jehovah witness who refuses a life-saving blood transfusion because of her/his religious beliefs. In this case, to coercively administer the blood transfusion would infringe on patients' liberty, for patients who are competent have a right to veto medical interventions that contrast with their values—even if such refusal may lead to severe health consequences such as death.

As a positive obligation, instead, clinicians have a duty to promote patients' autonomous decision-making by providing all the necessary information and by fostering their understandings.³⁶ This duty, inspired by a Kantian conception of autonomy as the capacity to act according to a self-chosen plan, implies that respecting patient's autonomy requires the actual aid of the clinician, for many “autonomous actions could not occur without others' material cooperation in making options available. Respect for autonomy obligates professionals in health care and research involving human subjects to disclose information, to probe for an ensure understanding and voluntariness, and to foster adequate decision making” (Beauchamp and Childress 2009, 104).

In this sense, respecting patients' autonomy means enhancing patients' autonomous agency. The concept of “autonomous agency” may be further unpacked in two conditions: the

³⁶ Beauchamp and Childress (2009) do not distinguish between autonomy and liberty, as they regard them as two sides of the same coin: the principle of respect for patients' autonomy. However, to avoid terminological confusion, I prefer here to adopt the perspective proposed, among others, by Coggon and Miola (2011, 525), for which it is important to distinguish “between autonomy as it refers to matters concerning the freedom of the will, and as it relates to political freedom within a society to act unencumbered by the interference of third parties or the State... For our purposes, *autonomy* relates to free will, so an “autonomous agent” is someone with free will, and *liberty* relates to freedom to act without the interference of third party”. Thus, a prisoner may enjoy a high level of autonomy whilst having extremely limited liberty, and a person with a low “mental age” will have a low level of autonomy whilst potentially having a great deal of liberty”. See also Dworkin (1998) and Jennings (2007).

one of (i) intentionality and the one of (ii) understanding. According to the first condition, an autonomous act is such only if it is intentional. Hence, someone who is sleepwalking cannot be considered autonomous. According to the condition of understanding, instead, persons “understand if they have acquired pertinent information and have relevant beliefs about the nature and consequences of their actions” (Beauchamp and Childress 2009, 127). An adequate understanding requires not only the ability to comprehend information, but also the availability of such information. How can someone refuse an intervention if one does not know that she is receiving one? Consider the following account from an oncologist in Northern Italy:

During my first year of oncology fellowship in Italy in 1983, a middle-aged businessman was told he had gastritis, when dying of cachexia from end-stage carcinoma; a young, divorced housewife was told she had arthritis while receiving palliative radiation therapy for chemotherapy-resistant metastatic breast cancer; and a college student was told he had drug-induced hepatitis, but he was indeed progressing toward liver failure from widespread hepatic involvement with lymphoma (Surbone 1992, 1661).

In all these cases, the patient’s family (or at least one family member) was informed of the truth. And yet, this practice prevaricated patients in a way that is incompatible with the respect of individual autonomy (but see Surbone 1992). By providing false diagnostic information, none of those persons had the opportunity to decide how to spend the last moments of their life, or how to settle their affairs. Perhaps more importantly, none of the above patients had a saying on what kind of cures she or he wanted to receive. In the case of terminally ill oncological patients this issue is even more pressing, as today there exist several different options that might be simultaneously implemented, such as palliative care. The decision on when and if someone is willing to switch from therapeutic to palliative chemotherapy, for example, may hugely impact the quality of life of terminally ill patients.³⁷

³⁷ The idea that respecting patients’ autonomy entails something more than simply refraining from lying and deceiving it at the core of any attempt that identify shared-decision making as a desirable goal of any therapeutic relationship. I agree with Jackson (2001, 10-11) that it is not true that in the past patients were forced to take medicines or undergo surgery; although in different ways, consent has always been part of the medical practice. Rather, what is new in the contemporary insistence on autonomy is “the idea that patients should be encouraged to participate in reaching decisions as to what treatments or procedures are appropriate for them. It is this right to participate in deciding what is appropriate that spurs the call for full and frank information-giving”. Without veracity one cannot have substantially autonomous agents, and thus shared-decision making. As noted by Joffe

Thus, through deception, clinicians may prevent patients from achieving an adequate understanding of their clinical situation, thus impairing their capacity for autonomous decision-making. Hence, the first argument concludes, if clinicians have a duty of respecting patient's autonomy, and if deception disrespects patient's autonomy, then clinicians should have duty of not deceiving patients.

(3.1.b) Deception, trust, and professional trustworthiness

The second argument concerns the trust between doctor and patient, and is often based on the claim that dishonesty threatens patient's trust:

Trust

- (i) Clinicians must preserve patient's trust
- (ii) Deception threatens patient's trust

Clinicians must not deceive patients

In the last years several authors have emphasized the role of trust in medicine (Bok 1978; O' Neill 2002; Jackson 2001; Jones 1996; Hardin 1996 and 2002). However, as Baier (1995) noted, in moral philosophy there have been a 'strange silence' on this topic. This is surprising given the central role that is normally attributed to trust in our private and public life:

Everyday life is a catalogue of success in the exercise of trust. Our dealings with friends and enemies, neighbors and strangers depend on it, whether in homes, streets, markets, seats of government or other arenas of civil society. Would you ask a stranger the time unless you could normally count on a true answer? Could you use the public highway without trusting other drivers? Could an economy progress beyond barter, or a society beyond mud huts, unless people relied on one another to keep their promises? Without trust social life would be impossible (Hollis 1998, 1; quoted in Jackson 2001, 132).

and Troug (2010, 349), however, the concept of "shared decision making" is often unclear; "Wide agreement on this label [...] masks deep uncertainties about its precise meaning. The term is often used without definition or further explanation, and likely means different things to different authors".

Trust is fundamental in any cooperative endeavor, and it is so pervasive in our lives that it is as if we “inhabit a climate of trust as we inhabit an atmosphere, notice it as we notice air, only when it becomes scarce or polluted” (Baier 1995, 98). Trust is important because it sets our default attitude towards others’ behavior, reducing the complexity of our decisional landscape (Luhman 1979, 30).³⁸ So, unless we have reasons to suspect otherwise, we expect that people who are asked about the time will reply truthfully; that those who make promises will keep them; and, more generally, that in normal situations others “will play by the rules” (O’Neill 2002, 14). Truthfulness, honesty, and fidelity are not always what we get, but they are what we *expect* from others. If this were not the case, then we will need to suspect of every sentence, reply, statement, etc. made by others; as a consequence, cooperation and social life would become impossible. In this general sense, “to trust someone” entails both an expectation and a positive attitude about others’ behavior and motives of actions.³⁹

While trust is important in any cooperative endeavor, it is especially important in medicine because of the peculiarity of the doctor-patient relationship. To fully unpack this latter claim, however, it is necessary to introduce four important considerations about the specific nature of the trust- relationship occurring between doctors and patients.

First, trust must be distinguished from trustworthiness.⁴⁰ As Hardin (1996, 28-9) noted, “trust by itself [...] constitutes nothing [...] without [trustworthiness], there is no value in trust”. Following McLeod, trust can be defined, “as an attitude that we have towards people

³⁸ Luhmann (1980, 30) observed, “Trust then is the generalized expectation that another will handle his freedom, his disturbing potential for diverse action in keeping with his personality, or rather in keeping with the personality which he has presented and made socially visible. He who stands by what he has consciously or unconsciously allowed to be known about himself s worthy of trust” (quoted in Pellegrino1991, 71).

³⁹ Trust may involve both cognitive and non-cognitive components; as Jones (1996, 5) noted, “Trusting is composed of two elements, one cognitive and one affective or emotional [...] Roughly, to trust someone is to have an attitude of optimism about her goodwill and to have the confident expectation that, when the needs arise, the one trusted will be directly and favourably moved by the thought that you are counting on her”. On the same issue see also Miller (2000), who builds on the previous work of Baier (1995) and Jones (1996).

⁴⁰ There are many kinds of trust-relationships, as the verb “to trust” can be used in expressions that do not involve, strictly speaking, individual agents. Consider the following expressions: “I trust myself”; “she trusts the stars”; “society trusts the market”; “citizens must trust their government”; “Othello trusts Iago”. The paradigmatic example of a trust relationship, however, is the last one, i.e. a relationship involving only two individuals: the “trustor” (e.g. Othello) and the “trustee” (e.g. Iago). I shall consider only trust-relationships of this latter kind; more specifically, I shall consider only the trust grounding the doctor-patient relationship.

whom we hope will be trustworthy, while trustworthiness is a property, not an attitude” (McLeod 2011). Ideally, those who are trusted are also trustworthy, but this is not necessarily the case. Trust can be misplaced, as for example when a patient trusts a quack. Vice-versa, someone may instead fail to trust someone who is trustworthy—as when nobody trusted Cassandra’s prophecies. In general, trust is “well placed” or “warranted” whether those who are trusted are also trustworthy (McLeod 2011).⁴¹

The distinction between trust and trustworthiness adds a layer of complexity to the moral analysis of trust-relationships in clinical settings. To some extent patient’s trust depends on the clinician’s trustworthiness, but it not reducible to it. Patients can be partially or wholly unreasonable, and so they can unreasonably mistrust a clinician who is instead perfectly trustworthy. One thing is clinicians’ trustworthiness *per se*, quite another is clinicians’ *perceived* trustworthiness for patients. Thus, it is perhaps more precise to say that “clinicians have an obligation of being *trustworthy*” rather than saying that “clinicians must preserve patient’s *trust*”—as this latter variable may be partially or wholly beyond clinicians’ control.⁴²

Second, clinicians’ trustworthiness flows from their status as socially recognized professionals.⁴³ Though patients may know their doctors quite well, the doctor-patient

⁴¹ In the last decades scholars have begun to provide increasingly sophisticated analyses of trust and trustworthiness (Hardin 2002; McLeod 2011). Scholars have recognized other distinctions that are of importance: (i) trust entails that someone who trusts (the trustor) become vulnerable to those who are trusted (the trustees): trust is invariably risky, and exposes the trustor to the possibility of betrayal (Hardin 1986; Miller 2000); (ii) trust implies that the trustor thinks well of the trustee, at least in certain respects; (iii) trust implies that the trustor thinks that the trustee is competent in certain respects. In the case of the doctor-patient relationship, for example, to trust the doctor the patient must think that this doctor is competent, at least in some area of medicine. Finally, it is unclear whether a defining feature of trust relationships is that the trustor thinks that the trustee has some kind of motives (which can range from self-interest to moral commitments) to be trustworthy. On this latter point there exists considerable disagreement, see McLeod (2011) and Hardin (2002). To these features, Jones (1996, 15) added that “any adequate account of trust should be able to explain at least the following three fairly obvious facts about trust: that trust and distrust are contraries but not contradictories, that trust cannot be willed, and that trust can give rise to beliefs that are abnormally resistant to evidence”.

⁴² By the expression “bond of trust” I refer to the mutual relationship of trust between doctor and patient. Of course, this relationship entails not only a trusting patient and a trustworthy doctor, but also a trusting *physician* and a trustworthy *patient*. As this dissertation is in medical ethics, however, I will focus my analysis only on to the side of this relationship concerned with the clinician’s obligation of being trustworthy. However, I will also use the more general expression “bond of trust between patient and clinician” whenever we need to refer to the broader context in which mutual relationships of trust thrive in clinical settings.

⁴³ As Sokolowski noted (1991, 31) “the relationship between professional and client is a fiduciary relationship. The client trusts the professional and entrusts himself or herself—not just his or her possessions—to the

relationship may and should take place also between strangers.⁴⁴ This is what has been defined as the “elegant anonymity [of] professional trustworthiness; if I get sick away from home and must go the emergency room of an hospital, I can in principle trust doctors and nurses I have never met before...because they are presented as members of the medical profession, persons who are certified by the profession and who can, *prima facie*, be taken as willing to abide by its norms” (Sokoloski 1991, 31). Without the general trust that patients have in clinicians’ professional trustworthiness, therapeutic relationships between strangers would be impossible. This is even truer in contemporary clinical settings, where the care of a single patient is now entrusted to large teams of doctors, nurses, and technicians.⁴⁵

Thirdly, clinicians’ *professional trustworthiness* entails an explicit moral commitment. Unlike other relationships based on trust between peers and other professions, the doctor-patient relationship is structured around a power-asymmetry. In clinical settings patients are “condemned to a relationship of inequality with the professed healer, for the healer professes to possess precisely what the patient lacks—the knowledge and the power to heal” (Pellegrino 1981, 161). Every doctor-patient relationship is thus characterized by an asymmetry of power and knowledge. This power-asymmetry allows doctors—among others things—to examine, touch, manipulate, cut, and even replace parts of the patient’s body in ways that would be considered unacceptable outside therapeutic relationships.

professional. The professional is presented as trustworthy not primarily in the way a friend is found to be faithful, by having proven himself or herself in many situations, but by having been certified as a professional.” For a proposal on how to conceive this relationship in the clinical practice see Joffe and Trough (2010).

⁴⁴ Patients may know their doctors very well, thus turning their relationship of *interpersonal* trust into a relationship of *personal* trust. In the latter case, the doctor is not a stranger, and the patient may have different expectations and attitudes toward the professional’s trustworthiness, for example by supposing that due to their long established acquaintance the doctor would be willing to do for her something that other doctors would instead not be prepared to do (e.g. prescribing an off-the-counter medication). While these latter kinds of relationships are common in clinical settings, they introduce too many variables and are by definition personal and therefore hardly generalizable; thus I shall not consider this kind of trust-relationships here.

⁴⁵ Zaner (1991, 49) observed that for patients trust is unavoidable, and that “[p]atients must trust not only physicians, researchers, administrative personnel, manufacturers. They also have no choice but to trust a great many things: the material used to repair body parts, bandages, drugs, surgical equipment, and the like. They also have to trust numerous procedures; sterilization, the administration of anaesthetics, surgical techniques, referrals, the preparation of drugs, and so on”. However, for the sake of clarity and simplicity, henceforth we shall focus only on the most clear-cut and general case: a relationship of trust between one *generic* doctor and one *generic* patient, assuming that they have never met before.

Furthermore, patients are by definition in a vulnerable condition: they seek the aid of clinicians only when they are in need of help and are unable to care for themselves. The trust in clinicians' professional trustworthiness is the precondition of any therapeutic relationship and, at the same time, what exposes patients to some risks. As noted by Pellegrino, trust is always a double-edged sword, and "to trust and entrust is to become vulnerable and dependent on the good will and motivations of those we trust. Trust, ineradicable as it is, is also always problematic" (Pellegrino 1991, 69).

To counterbalance this power asymmetry, clinicians are demanded to respect a certain code of moral conduct. In this sense, the "fiduciary pact" between doctor and patient can be conceptualized as being grounded in a relation of reciprocity: society grants medical professionals their education, an high social and economic status, and the possibility of disposing of the power and authority which are intrinsic in therapeutic relationships; in exchange, clinicians must abide to a publicly agreed set of legal, institutional, and moral rules which regulate their behavior as they operate as medical professionals (Beauchamp and Childress 2009). At their core, these deontological constraints entail at least two elements: (i) a commitment toward technical competency; (ii) and the adherence to a public code of conduct inscribed in international and national declarations, ethical guidelines, professional codes of conduct, oaths, etc., and grounded in common morality (Pellegrino et al. 1991).

Fourth, clinicians' professional trustworthiness has an interpersonal as well as a public dimension. Whenever a patient loses trust in the professional status of a specific doctor, there might follow severe consequences for the quality of the doctor-patient relationship and for patients' care. Patients who distrust their physician may not undergo medical or diagnostic procedures they need; deliberately withhold information that might instead be useful to optimize their care; discontinue treatments and impair compliance; rely on other more exotic forms of medical assistance that may be more hazardous and safe than conventional medical care; and may look elsewhere to find health-related information. Without a minimum trust,

any clinical encounter becomes scarcely more useful than taking a bunch of random pills.

Trust is thus required to achieve the very ends of medicine.

There is, however, also a more public dimension that pertains to clinicians' professional trustworthiness, which depends not only on the individual attitudes of each patient but also on the attitudes of society—or of specific subpopulations toward medical professionals in general (Wood et al. 2006). This public aspect of clinicians' trustworthiness is what allows the “elegant anonymity” of medicine, and is also the precondition for any other individual therapeutic relationship.⁴⁶ Without the trust of the public in clinicians, both clinical research and care delivery could not exist. As for clinical research, societal trust is pivotal in securing the enrolment of patients and healthy volunteers in clinical trials (Kass 1996). Without social trust as a guarantee that researchers would not exploit patients, medical knowledge cannot advance without becoming unethically coercive and manipulative.⁴⁷ Protecting and fostering clinicians' professional trustworthiness is also crucial for delivering public health interventions, especially within problematic cultural and economic contexts.

Thus, to fulfill its very ends medical professionals must operate in a climate of minimal trust. This trust depends on the interplay of individual and public attitudes toward clinicians' professional trustworthiness. Therefore, to fulfill and foster the ends of the medicine “The medical profession must strive to preserve the trust patients holds in their physicians. It cannot abandon ethical standards [...] Individual physicians must work to forge strong alliances with their own patients, and the medical profession with the public, to preserve the integrity of the profession” (AMA 2001).

⁴⁶ Clearly, the interpersonal and public dimensions of professional trustworthiness are intermingled and they mutually affect one another: someone who distrusts Western medicine would likely distrust any individual physician trained in Western medicine; likewise, discovering that a single physician has been for years very dishonest may cast doubt on the honesty of the entire medical profession as a social and institutional enterprise.

⁴⁷ Public trust is so important to pursue clinical research that it has been observed a direct correlation between the perceived trustworthiness of medical professionals in certain populations and the availability of scientific data concerning the efficacy and safety of licensed drugs in such populations (Wood et al. 2006; Freimuth 2001).

How does deception threaten physicians' professional trustworthiness? In chapter (2) I have argued that speakers subscribe to an implicit promise of being truthful in their interpersonal communications, "warranting the truth" of their statements. This implicit promise is what motivates our general trusting attitude toward others in most of our social interactions. Liars infringe on this implicit pact in order to manipulate others. In clinical settings doctors using deception are similarly culpable of breaking this implicit promise about the social attitudes that we should have in our communications. In addition to this, however, clinicians make also an explicit promise of being truthful in their communications with their patients by taking explicit oath and by promising to abide to certain professional codes. By violating these implicit and explicit promises to be truthful, dishonest clinicians infringe on the fiduciary pact that justifies their status as medical professionals.

This violation of the fiduciary pact between medical professionals and society is problematic due to the power-asymmetry entrenched in the doctor-patient relationship. In fact, dishonest physicians set themselves apart from the very conditions that allow them to be in a position of authority and control with respect to a vulnerable patient in need of help. Every time clinicians deceive a patient they also set a dangerous precedent (Jackson 2001). They provide the impression that they are not fully committed to the professional and moral requirements to which they are supposed to abide in a reciprocal exchange for their social status and power. If a clinician can decide to "opt out" from the moral commitments entailed by the fiduciary pact with society, then who can guarantee that she will abide to all the other moral commitments? Who can trust a clinician who is known to be a liar, as she explains why a particular surgical procedure has did not succeed, and has led to medical complications? What guarantee do we have that she will not concoct an excuse simply to pursue her ends?

To sum up, the ability of clinical medicine to pursue its ends depends at least in part on patients' trust in clinicians' professional trustworthiness, i.e. in patients' belief and optimistic attitude toward the fact that clinicians and others involved in their care will be

sufficiently competent and morally committed as to pursue their best (medical) interests. Therefore, the second argument contends, if clinicians must strive to preserve and foster their professional trustworthiness, and deception threatens their professional trustworthiness, then clinicians must not deceive their patients.

(3.2) Deception, trust and autonomy

Dishonesty in the doctor-patient communication is morally problematic because it disrespects patient's autonomy and jeopardizes the fiduciary pact on which any meaningful clinical encounter is premised. Together, these two rationales provide the basis to support the view that, other things being equal, honesty in professional communication should be always preferred to dishonesty as clinician's default attitude. In this section we shall take a closer look at these two rationales, first exploring their relationship with nonmaleficence and then their mutual interdependence.

(3.2.a) Deception and nonmaleficence

While autonomy and trust-based arguments are both recurrent throughout the literature in medical ethics about deception, their relationship is seldom—if ever—clarified. For one thing, however, it is clear that both arguments can be reinforced by consequentialist considerations of nonmaleficence. While the infringement of patient's autonomy and the breaching of the bond of trust between doctor and patient provide by themselves sufficient reasons to make deception *prima facie* wrong, they are even more problematic whenever they lead to harm and exploit patients for reasons unrelated with the promotion of their health and wellbeing. Of course, not every deliberate act of dishonesty has a malignant intent, as deception can be also

“benevolent” or “well intentioned”. Consider the case of a deceptively administered placebo given to an anxious patient. In this case, the act of dishonesty can be criticized using autonomy or trust-based arguments, but not considerations of nonmaleficence, as this benevolent deception is done for the good of the patient and may not harm (but see 6.9.b).

The situation is different whenever deception is used to harm and exploit patients. In general, there are two ways in which someone can force someone else to act against her will: coercion and malicious manipulation (Bok 1978). Coercion implies threats or violence, as when someone is coerced into lending over his pocket under the threat of physical harm. Manipulation, instead, entails the malicious use of lies, deception or concealment in order to make someone acts against his or her will.⁴⁸ For instance, in Shakespeare’s *Othello*, Iago intentionally leads Othello into believing that Desdemona has cheated on him with Cassio. By instilling a series of false beliefs in Othello’s mind, Iago manipulates Othello’s in order to fulfill his own plan: taking over Cassio’s place as lieutenant. Shakespeare’s play underscores the coercive power that manipulation confers to those who are dishonest and the grime consequences that might follow for those who are manipulated.

Often, coercion and manipulation go hand in hand, as those who commit wrong deeds usually do not want others to discover what they have done. For example, murderers may deceive others to keep their plans secret, to cover up their traces afterwards, and to escape justice once caught by lying in the court during the trial. In these cases, the primary crime committed is the murder, but lies and deception are what facilitate and makes it is possible to commit and sometimes to get away with it.

⁴⁸ In (7.4) I will distinguish between skilful and malicious manipulation. In this chapter, however, I shall speak only of manipulation in the former, negative, sense.

In the history of medicine there are many cases in which the interplay of coercion and manipulation has led to abuses, exploitation and harm.⁴⁹ The infamous Tuskegee syphilis study is, again, a paradigmatic case of how dishonesty may lead to abuses that result in disastrous consequences. From 1932 to 1972, American researchers from the Public Health Service conducted a nontherapeutic study on untreated syphilis on over 400 black men. Not only none of these men was informed of being enrolled in a clinical trial but, in order to preserve the scientific validity of the study, they were left untreated even after an efficacious remedy for syphilis had become available. Untreated syphilis—it is worth underscoring—is a horrible disease that may lead to severe pain, scars, organ and tissue damages, mutilations, fever, headaches, tumors, ulcers, paralysis, insanity and death (Jones 2008). Obviously, it was only due to the lies, deceptive practices, and the strategic concealment of relevant information that this study had the possibility to be settled up and continued for forty years.

The case of the Tuskegee Study well illustrates how the breaching of the bond of trust between researchers and society, as well as the low moral significance attributed to others' autonomy, can sometimes be conducive to unethical cases of abuses, harm and exploitation. Therefore, aside and together with other considerations of respect for patient's autonomy and trust, an additional reason to avoid dishonesty is that it may often enable and be conducive to other kind of unethical conduct.

⁴⁹ The medical experiments conducted by Nazi and Japanese researchers on prisoners of war during the Second World War involved the use of physical coercion and threats. Against their will, hundreds if not thousands of persons were forced to take part in human experimentations that were often deprived of a sound scientific rationale and had no concerns for their psychological and physical integrity (Jones 2008). Likely, in many of these cases, the use of lies, deception and concealment facilitated or made possible these abuses—as when medical experiments are presented as being for therapeutic rather than for purely scientific purposes.

(3.2.b) Trust and autonomy

Clarifying the relationship between the rationale grounded in the respect for patient's autonomy and the one grounded in the preservation of patient's trust is problematic. Most scholars tend to endorse only one of the two, and thus to problematize the morality of deception either by underscoring its implications for patients' autonomy (Beauchamp and Childress 2009; Asai and Kadooka 2013; Foddy 2009) or for trust (Bok 1978; Jackson 2001). Even when both rationales are recognized, their relationship is often left unqualified, with one of the two taking the upper hand over the other. So how should we conceive the relationship between the respects of patient's autonomy and the preservation of trust in relation to the ethics of deception in medicine? Are concerns about the respect for patient's autonomy as important as those about trust, or should we assign a qualified priority to one of the two?

Based on what we have so far seen, I defend a position based on two key-ideas. First, both rationales provide independent and yet equally necessary conditions for the pursuit of clinical medicine as an ethical, useful and meaningful enterprise. Respecting patient's autonomy and preserving trust are two fundamental conditions without which any medical encounter would at best be sterile and at worse unethical. The first and most important goal of clinical medicine is to provide care for vulnerable patients: disrespecting patient's autonomy or failing to live up to the duties entrenched in the fiduciary relationship between clinicians and patients are both ways in which a clinician would fail *to properly care* for her patients.

Thus, in evaluating the morality of a deceptive act in clinical contexts, it is theoretically possible that considerations based either on the respect for patient's autonomy or on trust may independently provide two sufficient rationales to conclude that such an act of deception is unethical and ought therefore not to be performed. In most of the situations, however, trust-based and autonomy-based considerations are likely to be both relevant and interwoven.

The second idea, then, is that while the respect for patient's autonomy and the preservation of trust are both necessary conditions to pursue the ends of medicine, the latter is the only one which can be also a sufficient condition for fulfilling such ends. While respecting patient's autonomy is important in most situations, preserving trust is, instead, *always* important. Two reasons support this claim.

First, not every therapeutic encounter occurs between two competent and fully autonomous agents. Children, elderly persons, people with mental disabilities or impaired cognitive abilities, are all typical examples of vulnerable patients that may lack the capacities for autonomous decision-making. In these cases, it would be inappropriate to reason in terms of respect for autonomy (though there might be surrogate decision-makers). But whenever we can suspect that a patient is not competent and autonomous, preserving the bond of trust might still remain crucial for the success of the therapeutic encounter. Therefore, in evaluating the possibility of deceiving patients the preservation of trust would always be important, while the respect of patient's autonomy would represent a concern only in those cases in which there is either a fully competent patient or surrogate decision-makers.

The second reason is that, even in those cases in which the respect for patient's autonomy and the preservation of trust are equally important, fostering trust is often a necessary precondition for fostering autonomy. As we have seen, the principle of respect of patient's autonomy can be conceptualized in the terms of two complementary *prima facie* obligations: that of not infringing patient's liberty, and that of promoting patient's autonomous decision-making. In order to respect the negative obligation of liberty, there is no need of building a fiduciary relationship between clinician and patient. Indeed, the lack of trust may be one of the most common rationales for which a patient may decide to seek another medical opinion—hence ditching her present doctor.

Consider the case in which a patient is fully convinced that her doctor is manipulating her in order to sell expensive drugs that she does not need. She decides to change doctor out of her distrust in that particular physician. Assuming that she is a competent agent, then, and in order to respect her autonomy, the doctor has simply to let her consult another professional, even if the clinicians did in fact behave properly. In this scenario, the doctor may still respect patient's autonomy even in absence of a fiduciary relationship—indeed even in the presence of open distrust.

On any account, however, this clinical encounter is far from being an ideal one in which a patient and a doctor cooperate to achieve an improvement in patient's health and wellbeing. The patient has not received the help she needed, and the doctor has failed to provide medical care to someone who likely was in need of it. Both have lost time, probably money, and certainly their positive mood. Respecting patient's autonomy by refraining from infringing on patient's liberty is thus always important, but not sufficient to fulfill the positive ends of medicine. To achieve this latter aim something more is required, namely, the positive enhancement of patient's autonomy.

In order to respect patient's autonomy in this broader sense, however, a relationship based on mutual trust is always necessary because “for a person to be appropriately ‘informed’, much less uncoerced and free in giving consent, trust remains the sine qua non for the professional's disclosure of pertinent information, as well as for the actions proposed and carried out. Professional trustworthiness is still a critical issue in constant needs of warranting trust in every individual encounter” (Zaner 1991, 56). Therefore, not only preserving trust can be legitimately expected to be important in more situations than those in which respecting patient's autonomy would provide an equally compelling *prima facie* rationale to avoid deception (because not every patient is competent), but also in those cases in which the respect of patient's autonomy entails the positive empowerment of patient's agency, fostering trust remains a precondition for fostering autonomy.

To sum up, often the primary concern while evaluating the moral implications of dishonesty is the infringement of the fiduciary pact between doctor and patient and thus the possible loss of clinician's perceived trustworthiness. While concerns about autonomy and beneficence are always important, often it is the possible breach of the bond of trust the primary moral concern that ought to be considered while evaluating dishonesty in clinical contexts. Respecting patient's autonomy is a necessary but not a sufficient condition for the success of every therapeutic relationship, while preserving and fostering the bond of trust may be—and often is—a necessary and sufficient condition to achieve meaningful and positive therapeutic relationships.

(3.3) Deception and the “discrepancy of the perspectives”

Every act of deception requires someone who deceives and someone who is deceived. While from a logical point of view they are equally important, from a moral point of view there is usually a capital difference in how the two may appraise the moral implications of the same deceptive act. Dan Ariel (2012, 31), in his book *The Honest Truth about Dishonesty*, illustrates this point with the following joke:

Eight-year-old Jimmy comes home from school with a note from his teacher that says, “Jimmy stole a pencil from the student sitting next to him.” Jimmy's father is furious. He goes to great lengths to lecture Jimmy and let him know how upset and disappointed he is, and he grounds the boy for two weeks. “And just wait until your mother comes home!” he tells the boy ominously. Finally, he concludes, “Anyway, Jimmy, if you need a pencil, why didn't you just say something? Why didn't you simply ask? You know very well that I can bring you dozens of pencils from work”.

This joke underscores how we tend to appraise the morality of the same deceptive act in different ways depending on whether we are the ones who commits it or the ones who are subjected to it. Sissela Bok has defined this phenomenon as the one of “discrepant perspectives” in reference to lies, but her conclusions can be easily generalized to all other instances of deception (1978, 17-31). In this section I will build on Bok's analysis to show how

the phenomenon of the “discrepancy of the perspectives” may introduce a structural bias whenever we ought to identify and weight the reasons in favor or against a deceptive act. To do so, let us briefly explore how the deceiver and the deceived may come to articulate differently their views with respect to the same deceptive act.

Let us first take a closer look at the perspective of the deceived. Usually, people who discover that others have deceived them about something important feel betrayed and coerced (Bok 1978). Imagine that you discover you have a rare genetic disease but that your parents have concealed this information. Suddenly, the symptoms begin to appear and, after the first medical consultation, it is clear that your life will never be the same: the disease will progress rapidly, and your entire life-plan needs to be reconsidered. Contrary to your expectations, you will not marry, change job, or travel. Moreover, you do not know if you have already transmitted the disease to your kids; because you were left in the dark, you could have harmed others without intention. It is hard to see how one would not feel unjustly manipulated in this situation. Moreover, that those who lied were the parents may aggravate the situation: the more we trusted those who have deceived us, the more we feel betrayed by them.

Deceiving over such important matters is not easy to excuse, not even when others declare that they have acted “for our own good”. In the previous example, our parents could justify the deception by saying that they wanted us to live a happy life until the onset of the disease. Though comprehensible to some extent, one can always object to this decision as unjustly paternalistic. When we assume the perspective of the deceived, we tend to blame others not only for the consequences of the deception, but also because they have prevented us from acting as we would have done if we had known the truth. Even if the final outcome was “for the good”, in these situations we may nonetheless feel wronged because we were deprived of our capacity for self-determination. This may lead the deceived to devalue what has been achieved through the act of benevolent or paternalistic deception. By contrast, it is usually hard

for those who act paternalistically to imagine what it feels like to be manipulated, and thus to assess all the consequences of their actions from the point of view of those subjected to them.

Of course, the situation is even worse when we also find ourselves worse off because of the deceivers' behavior. In these cases the blame for their betrayal is summed to the perceived disrespect for our autonomy and to the costs and negative consequences that we suffered because of the deception. This deception must not regard important issues to be morally problematic, or to have significant consequences. As noted in previous chapters, lies, deception and concealment often lay on a continuum. Sometimes lies are just trivial, and the acts of deception amounts to nothing but a white lie. Yet, by assuming the perspective of the deceived, also the most trivial of the lies may induce the most corrosive of the suspects. As noted by Bok, "since we, when lied to, have no way to judge which lies are trivial ones, and since we have no confidence that liars will restrict themselves to just such trivial lies, the perspective of the deceived leads us to be way of all deception" (Bok 1978, 21).

Finally, the perspective of the deceived is not just an individual affair. Everyone who bears the consequence of an act of dishonesty may come to share the same point of view. The consequences of discovering that a beloved relative has died because of a medical error, which then clinicians have tried to hide, are likely to invest not just the closest caregivers, but also everyone who was sufficiently attached to that unfortunate person. And if the case is made public, other people may as well assume the "perspective of deceived", generalizing from that particular case to their own particular situation.

By contrast, those assuming the deceiver's perspective have usually very different concerns. People can deceive because they have selfish interests, for the fun and pleasure of it, for the good of others, or to achieve greater goals. In any case, "[liars] share with those they deceive the desire not to be deceived. As a result, their choice to lie is one that they would like to reserve for themselves while insisting that others must be honest. They would prefer, in

other words, a “free-rider” status, to get all the benefits of lying without the risks of being lied to (Bok 1978, 23). (Would the parents in the previous example be happy to discover that their son has deceived them on something of comparable importance?) To justify their free-rider status, the deceivers may invoke different personal or professional reasons, like physicians and healers in the past who reserved from themselves the possibility to lie to patients while pretending from them a full commitment to truthfulness. Usually, the deceivers tend to disguise their selfish motives of action as altruistic ones, claiming that the deception was not meant for their private good, but for those of the deceived.

While assuming the perspective of the deceiver, people tend to judge themselves in a benevolent and optimistic way, detailing all the circumstances that justify their behavior while downplaying the costs and risks of their decisions for others. As Bok notes, “The most serious miscalculation people make when weighing lies is to evaluate the costs and benefits of a particular lie in an isolated case, and then to favor lies if the benefits seem to outweigh the costs. In so doing they risk blinding themselves to the effect that such lying can have on their integrity and self-respect, and to the jeopardy in which they place others” (Bok 1978: xix). For example people tend to judge the same situation quite differently depending on whether they are the cheaters or the ones that have been cheated on.

To see how the “discrepancy of the perspectives” can lead to suboptimal moral decisions, consider the example of a fictional court of law that is called to decide about a criminal accusation. There are only three persons who are participating in the trial: the victim, the judge, and the indicted. The trial is organized in three moments: first it is randomly selected whether it is the victim or the indicted the one who will first present her version of the facts, then there is the actual exposition, and finally the judge emits a verdict. The judge is called to decide only after she has heard both the perspective of the victim and the one of the indicted, and has had the opportunity of appraising and pondering their respective force.

Now, consider what would happen if either the indicted or the victim would assume the role of the judge: would the final verdict be equally impartial as when it is pronounced by a non-interested party? Probably not, for this is precisely why an impartial judge is needed in the first place. If those who are indicted become the judges, then they will tend more often than not to excuse themselves and to assign to themselves lighter punishments with respect to completely impartial judges. Likewise, if the victims become the judges, then they will tend more often than not to condemn the indicted and to assign them heavier punishments with respect to what impartial judges would tend to do. In both cases, the final verdict is likely to be skewed in one sense or the other. Arguably we are not very impartial as we are called to decide upon matters in which we have high and potentially conflicting personal interests.

These biases would become even worse if either the victim or the indicted assume both the role of the judge and that of their counterpart. In this scenario, not only one would emit the verdict while being in “conflict of interests”, but such a conflict would also not be mitigated by hearing the other’s reasons, that is, either the reasons of those who have committed something blameworthy or the reasons of those who have been subjected to those culpable actions. Bok’s intuition about the “discrepancy of the perspective” is that whenever we are privately evaluating the morality of a deceptive act the same considerations apply; and it is thus safe to assume that neither those who deceive nor those who are deceived can be considered as fully impartial and fair judges of such an action: the deceivers will tend to excuse their behavior, while the duped will tend to magnify the moral blame of the deception.

How could the “discrepancy of the perspective” influence the way in which we should evaluate the morality of a deceptive act in clinical settings? Based on what we have seen in previous chapters, there are at least three levels at which this phenomenon may introduce a bias in our moral judgments. First, it may influence the way in which we recognize that we are lying, deceiving and concealing information to others; that is, it may influence our awareness about our own dishonesty (Ariel 2012). Secondly, it may distort our moral evaluations.

According to the Rossian theory that I have assumed, once two *prima facie* obligations are in conflict we need to determine what is our *actual* obligation in those specific circumstances. To do so, we have to balance the reasons supporting the case for one obligation with those supporting the case for the conflicting one, determining which one overrides the other all things considered. Here the discrepancy of the perspective may introduce a twofold bias: it may lead us to cherry-pick the reasons in favor or in support to a given deceptive act; and it may lead us to assign skewed weights to the reasons that are in conflict with our interests with respect to those that are contrary to them. Either way, we are likely to take biased decisions as to which obligation should be our actual duty in any one case.

In sum, the moral phenomenon of the “discrepancy of the perspective” points at a structural unbalance between the ways in which those who deceive and those who are deceived may appraise the consequences, severity, and respective weights of the same deceptive act. If this is correct, then it follows that, while evaluating the morality of a deceptive act, considering only one of the two sides is never enough, for each is likely to be biased and limited. Therefore, to take more fair and impartial judgments, for each act of deception we must always consider both the deceiver and the deceived’s perspective.

(3) Summary

In this chapter I have discussed two arguments supporting the view that dishonesty is *prima facie* wrong in clinical contexts: the first concerns the principle of respect for patient’s autonomy; the second concerns the preservation of trust between doctors and patients. Then, I have argued for the view that both rationales provide necessary conditions for having a positive clinical encounter, but that in many cases trust is to be expected as the sole sufficient condition. Moreover, following Bok’s account, we have also seen how we have a structural tendency in our judgments to evaluate the same deceptive act differently depending on

whether we assume the deceiver or the deceived's perspective; and thus how the "discrepancy of the perspectives" may introduce a structural bias in our moral justifications.

4. Deception and Moral Justification

When regard for truth has been broken down or even slightly weakened,
all things will remain doubtful.

St. Augustine

Is it good for us professional men to have our reputations rest on the expectation of not being
found out?

Richard Cabot

(4) Introduction

This chapter analyzes the limits of other accounts that have been elaborated to deal with the moral implications of deception in clinical medicine. Section (4.1) identifies six different positions depending on whether (i) one assumes trust, autonomy or both as the main rationale(s) to avoid deception—hence distinguishing between “autonomy-based”, “trust-based”, and “balanced” positions—, and on whether (ii) one allows or not for qualified exceptions to the duty of veracity—hence distinguishing between “categorical” and “exceptionalist” positions. Section (4.2) sets forth the view that all categorical positions equally fail in providing an adequate theoretical framework to think about the morality of deception in medicine. Section (4.3) explains why the dominant perspective currently endorsed in medical ethics—i.e. Beauchamp and Childress’s “justified hard paternalism”—is problematic because it does not take into adequate consideration some key features characterizing the morality of deception. Finally, section (4.3) inquires into the limits of the categorical trust-based account elaborated by Jackson (2001), showing how it misconstrues the moral phenomenon of trust

(4.1) Dishonesty in medical ethics: six possible positions

So far I have defended a position according to which we should allow for some exceptions to clinicians’ duty of veracity: while truthfulness is extremely valuable in medical contexts, sometimes there are greater values at stake which might compel clinicians to resort to dishonesty. But how can we distinguish those cases in which situational dishonesty is morally permissible from those in which we should instead stand firm by the duty of veracity? The answer to this latter question largely depends on the position that one assumes as to why dishonesty is morally problematic in the first place.

In the previous chapter I argued that there are at least two equally necessary and independent reasons to conclude that dishonesty is undesirable in medicine: one regards the respect of patient’s autonomy, and the other the preservation of the bond of trust between doctors and patients. Though almost any view acknowledges the importance of these two rationales, there are significant differences as to the weight that various accounts assign to them. In particular, within contemporary medical ethics, there exists a relevant difference between those perspectives that assign a theoretical priority to the rationale grounded in the principle of respect of autonomy and those that, instead, assign a priority to the rationale centered on trust. Accordingly, a first major difference is between “autonomy-based” and “trust-based” views. Clearly, another logical possibility is that of recognizing both rationales are equally necessary and important; in this latter case I shall speak of “balanced” perspectives.

The second difference regards whether one allows for exceptions to the duty of veracity. Here there are but two possibilities: “categorical” positions that do not allow for exceptions; and “exceptionalist” positions that, instead, do allow for exceptions and regard the duty of veracity to be a *prima facie* duty. With these differences in mind, it is possible to capture most of the positions now uphold in medical ethics within the following schema:

(I) Categorical Autonomy-based	(III) Categorical Trust-based	(V) Categorical Balanced
(II) Exceptionalist Autonomy-based	(IV) Exceptionalist Trust-based	(VI) Exceptionalist Balanced

In the next chapter I will articulate a balanced exceptionalist view (vi in the above schema). This view is “balanced” because it identifies in the preservation of patient’s trust and in the respect of patient’s autonomy two equally important aspects that should always be considered while evaluating the moral implications of a deceptive act; and it is “exceptionalist” because it allows for qualified exceptions to the duty of veracity, which is then conceptualized as a *prima facie* duty and not as a categorical obligation. This position, I will argue, is superior to other solutions because it avoids some of their major limitations while having some significant advantages.

To unpack this latter claim in this chapter we shall analyze some of rival solutions that other scholars have set forth to deal with the morality of deception in clinical medical. We shall review the positions (I), (II), (III), and (V), underscoring in each case their possible limitations. We shall proceed in the following way. First, I shall criticize all categorical views (I-III-V) insofar as a commitment to absolute veracity expose them to the same general critiques. Then, I shall criticize the dominant approach in contemporary medical ethics (II): the autonomy-based exceptionalist position elaborated by Beauchamp and Childress in their classical *Principles of Biomedical Ethics*. Finally, I shall refute some of the arguments that support another alternative that is currently gaining momentum in medical ethics: the categorical trust-based position (III) defended, among others, by Jackson (2001).

(4.2) The limits of categorical positions

According to categorical positions, dishonesty is never justifiable in clinical settings. In general, there are two classical critiques advanced to categorical views: one concerning the legitimacy of the conflicts of duties arising in medical contexts, and the other related to the practical difficulty of specifying the limits of a categorical ban of dishonesty. As we have

already discussed the main arguments underpinning these two critiques in previous chapters, here we shall only recapitulate their main tenets.

The first critique is that clinicians' obligation of veracity may legitimately conflict with their obligations of beneficence or nonmaleficence (see 1.4.d). As in the case of the "murderer at the door", sometimes it is highly counterintuitive to argue in favor of a categorical duty of veracity. Likewise, in medical contexts clinicians must often face what seem to be legitimate moral dilemmas involving a conflict of obligations. A typical example is when oncologists must disclose bad prognostic news to highly vulnerable patients. While there are several ways in which the impact of bad news can be mitigated, sometimes a clinician may suspect that by disclosing the truth she will irremediably harm her patient in a way that is incompatible with the provision of care and with the respect of the patient's dignity. In these cases it arises for clinicians a moral dilemma involving, on the one hand, their duty of veracity and, on the other hand, their duties of beneficence and nonmaleficence. Though these cases may be rare, in such exceptional circumstances it is generally recognized that the clinician may justifiably opt for paternalistic deception. For this reason, categorical positions are rarely upheld in medical ethics without important qualifications.

Another challenge faced by categorical views is that of specifying the limits of their categorical ban. In fact, whenever this ban is extended to every kind of dishonest practices including deception and concealment, categorical positions seem to become too demanding. A duty of absolute honesty entails not only that clinicians must never lie, but also that they must never deceive. In difference to the definition of lying, however, the one of deception is much broader and it far from clear that all acts of deception should be considered morally problematic. Recall that deception is generally defined as "intentionally causing someone to have a false belief that the deceiver believes to be false" (Chisholm and Feehan 1977; Carson 2010, 46; Gold and Lichtenberg 2014, 220). According to this definition someone wearing

black clothes to look thinner would be technically deceiving others, as this would qualify as an attempt to instill a false belief about his or her real body-shape.

This conclusion, however, is highly counterintuitive, as there seems to be a relevant moral difference between someone who is deceiving a person about her previous studies (e.g. by exercising the medical profession with a fake medical degree), and someone who is instead wearing the clothes that she thinks would look best on her (see below). In fact, we may rightly feel betrayed by the first person—i.e. the fake doctor—and not from the second, as in common circumstances we do not expect others to look “exactly as they are” in order to be moral agent. Likewise, people using make-up are generally not accused of misleading others about their real appearance. Thus, whenever a duty of honesty includes all possible forms of technical deception, it leads to counterintuitive consequences.

One possibility to escape this objection is to limit the categorical ban only to lies. Given that analysis done in chapter (2), however, also this theoretical option seems to run into insurmountable difficulties: in practice there is no sharp moral difference between lies and deception, as they are always context-dependent and audience-sensitive. Lies are generally more culpable than deception, but there are clear cases in which it is precisely the reverse. Sometimes an act of deception can disrupt trust and disrespect patient’s autonomy more, or at least equally, as the telling of an open lie; in other contexts, instead, lies may not be morally problematic, as when someone replies “Good” to the generic question “How are you today?” even if she is not feeling perfectly right.

Furthermore, supporters of a categorical ban on lies tend also to endorse a too relaxed view concerning the moral relevance of deception. In fact, in order to justify the limitation of the categorical ban only to lying, these views must emphasize the moral differences between lying and deception. Though these difference may appear clear in *ad hoc* fictional scenarios,

they are generally more blurred in real contexts where lies and deception tend instead to “spill over” one into the other (see 2.2). On this issue I side with Bakhurst (1992, 63) who noted,

the claim that there is a general, morally relevant difference between lying and intentional deception is false [...] the resulting position trivialises the moral significance of deception, and encourages a form of medical paternalism, where doctors may, ‘for the patient’s well-being’, control the ‘dosage’ of information the patient receives, so long as they do not lie. This seems a position designed to satisfy no one: while advocates of paternalist medicine will resist the restriction against lying (if paternalism is justified why be weak-kneed about it?), its opponents will charge [those defending this position] with supporting practices that, however well intentioned, are ultimately degrading to patients.

Thus, limiting the categorical ban to lies seems to introduce theoretical difficulties that are at least as problematic as those that such proposal was meant to resolve in the first place.

In sum, categorical positions run into two general difficulties. First, they are ill suited for medical contexts where the primary duty of the clinician is not toward veracity but toward helping vulnerable patients. Other things being equal, doctors should be truthful to their patients. However, sometimes things are not equal, and therefore clinicians have to choose between conflicting duties. Second, there are several practical and theoretical difficulties that arise from the very idea of applying a perspective that is “categorical” to something that is context and audience-dependent as veracity in interpersonal communication. In particular, these views are open to the criticism concerning the extension of their categorical ban. If the ban is intended in an absolute sense, then it becomes clearly too demanding, as it would turn socially accepted practices into morally blameworthy acts. If, instead, the ban is limited only to lies and not to deception, then these views introduce an untenable difference between the moral import of lying and deception which then lead to endorse a too rigid perspective on lying and a too relaxed approach on the risks of condoning deceptive practices.

(4.3) The limits of exceptionalist autonomy-based positions

The second kind of positions that we shall analyze are those that are autonomy-based and exceptionalist. For these perspectives the key moral issue pertaining to the use of lying, deception and concealment in medicine regards the infringement of patient's autonomy. However, these perspectives are also exceptionalist, as they specify the principle of respect for patient's autonomy in terms of two *prima facie* duties: the negative obligation to respect patient's liberty, and the positive obligation to respect patient's autonomy (see 3.2).⁵⁰ This position is by far the dominant one in the medical ethics.

According to Beauchamp and Childress (2009), whenever doctors lie and deceive for “the good of the patient”, they are acting paternalistically. Accordingly, to decide whether our actual duty is to deceive a patient in a given scenario, we should ask whether the corresponding act of medical paternalism is morally justifiable. Consequently, the problem of justifying a deceptive act becomes, for those supporting this view, the problem of justifying an act of medical paternalism, where “paternalism” is here defined 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 preventing or mitigating harm to the person whose preferences or actions are overridden” (Beauchamp and Childress 2009, 208).

However, not every act of paternalism is equal, and we should distinguish between *soft* and *hard* paternalism. In cases of soft paternalism, the clinician intervenes for the patient's good with the aim of preventing substantially *nonvoluntary* conduct. Examples of agents who act nonvoluntary are those in which people are severely depressed, mentally ill, or are under the effects of drugs that prevent them from acting competently. In all these cases the autonomy of the agent is compromised, and thus any paternalistic act would qualify as an act of soft paternalism. For example, if we prevent someone having drug-induced hallucinations

⁵⁰ Consistently with the previous chapter, by “autonomy” I shall here mean the principle of respect for autonomy as Beauchamp and Childress have articulated it in their classical *Principles of Biomedical Ethics* (2009).

from jumping off a bridge, we would act paternalistically, as we would infringe on this person's liberty of action. But since this person is also temporarily not an autonomous agent due to the effects of the drugs, then our act would qualify as an act of *soft* paternalism. Usually, soft paternalism is considered to be morally justifiable, as the infringement of patient's autonomy is either negligible or non-existent since the patient was not able to decide and act autonomously in the first place.

By contrast, in the case of *hard* paternalism, clinicians infringe on patient's autonomy by restricting/distorting the information available to the patient or by overriding patient's deliberate choices. A paradigmatic example of hard paternalism is when a clinician decides to withhold information about a bad diagnosis or prognosis on the supposition that breaking this news would have fatal or irreversible negative effects for the health of the patient (Beauchamp and Childress 2009, 211). This is the only class of cases that is relevant for the present analysis, and consequently the only one that we shall now analyze.

Thus, the question becomes: following this view, how can we distinguish those cases in which hard paternalism is morally permissible? According to Beauchamp and Childress, the answer to this question is that hard paternalism is more easily justified whenever the prospective infringement of patient's autonomy are minimal and the benefits relevant or, more precisely, "As a person's interests in autonomy increase and the benefits for that person decrease, the justification of paternalistic action becomes less plausible; conversely, as the benefits for a person increase and the person's autonomy interests decrease, the justification of paternalistic action becomes less plausible" (Beauchamp and Childress 2009, 214). To specify this position, they propose (Beauchamp and Childress 2009, 216) the following five conditions in which hard paternalism can be justified:

1. A patient is at risk of a significant, preventable harm.
2. The paternalistic action will probably prevent the harm.

3. The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
4. There is no reasonable alternative to the limitation of autonomy.
5. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted

At the level of public interventions, a typical example of a hard paternalistic intervention meeting all these conditions is the mandatory law of wearing seatbelts while driving. This law is paternalistic because the state infringes on citizen's liberty of not fastening their seatbelts. But why is such paternalistic policy morally justifiable? Following the above criteria, the answer is that not wearing seatbelts exposes patients to the risk of significant and preventable harm; enforcing a policy of wearing seatbelts will probably prevent this harm; the projected benefits vastly outweigh the risks; population-wise, these risks cannot be prevented by other means than making seatbelts mandatory; seatbelts represent the least autonomy-restrictive alternative available (rather than, say, forbid driving). In the case of seatbelts, Beauchamp and Childress's view seems to provide an adequate way of determining why such an intervention is justifiable. In this example the act of hard paternalistic concerns a public intervention at the population level. Nevertheless, the criteria proposed by Beauchamp and Childress seem to capture the fundamental features of this scenario inasmuch as the law of enforcing seatbelts infringes on individual liberty, and individual liberty is one of the conditions for exercising individual autonomy. But the same perspective applies to similar cases in medical contexts, as the following one:

After receiving his preoperative medicine, C, a 23-year-old male athlete scheduled for a hernia repair, states that he does not want the side rails up. C is of clear mind and understands why the rule is required; however, C does not feel the rule should apply to him because he is not the least but drowsy from the preoperative medication and he has no intention of falling out of bed. After considerable discussion between the nurse and patient, the nurse responsible for C's care puts the side rails up. Her justification is as follows: C is not drowsy because he has just received the preoperative medication, and its effects have not occurred. Furthermore, if he follows the typical pattern of patients receiving this medication in this dosage, he will become drowsy very quickly. A drowsy patient is at risk for a fall. Since there is no family at the hospital to remain with the patient, and since the nurses on the unit are exceptionally busy, no one can constantly stay with C to monitor his level of alertness. Under these circumstances the patient must

be protected from the potential harm of a fall, despite the fact that he does not want this protection [...] The nurse restricted this autonomous patient's liberty based on [...] protection of the patient from potential harm [...] and *not* as a hedge against liability or for protection from criticism (Beauchamp and Childress 2009, 215).

Like in the case of seatbelts, Beauchamp and Childress argue that the decision of the nurse represented an instance of hard but justified paternalism. In fact, the patient was at risk of harming himself and that harm was easily preventable; the putting up of the side rails is efficacious in preventing this harm from happening; the prospective benefits clearly outweigh the “risks” of having side rails around one's bed; no other alternative was available to prevent that kind of harm; side rails were the least autonomy-restrictive measure (e.g. in compares to, say, tying up the patient to the bed). Both in the seatbelts and in the side-rails case, Beauchamp and Childress's account of justified hard paternalism accounts for why such paternalistic restrictions of liberty appear to be morally justifiable all things considered.

However, this perspective is not unproblematic. In particular, lies and deceptive communications are not side-rails, and the moral phenomenon of dishonesty has several distinctive features that here are not taken into adequate consideration. In particular, dishonesty has significant implications for the preservation and the fostering of the bond of trust between doctor and patient. While the perspective of justified paternalism endorsed by Beauchamp and Childress—and by reflection by most of mainstream medical ethics—may provide a reliable tool for deciding whether instances of hard paternalism are justified in cases analogous to the one of side-rails, it is at least questionable whenever it applies equally well to cases in which the paternalistic act involves dishonesty. More specifically, and given what we have seen, I argue that, contrary to what is usually assumed, whenever this perspective is applied to justify cases of benevolent deception it runs into serious objections.

(4.3.a) Overemphasizing autonomy, downplaying trust

By definition, autonomy-based perspectives consider the infringement of patient's autonomy to be the chief moral issue entailed in the use of dishonest practices. In fact, following these views, in order to decide whether or not an act of deceptive hard paternalism is justifiable, we must balance considerations of nonmaleficence and beneficence against considerations of respect for patient's autonomy. Focusing only on considerations of autonomy may be appropriate for paternalistic acts such as the State's policy of making seatbelts mandatory, but less so in the case of lies, deception and concealment of medically relevant information.

The paternalistic rationale justifying the mandatory enforcing of seatbelts does not entail any breach of trust between the State and drivers; nor does so the example of the nurse: indeed the patient would perceive the putting up of side rails as a constrain of his liberty rather than as a betrayal of some obligations of fidelity. By contrast, the case of a deceptive placebo sneaked into a patient's injection seems to call into question a different moral phenomenon, as it does not only infringe on patient's autonomy but it also potentially compromises the trust between doctors and patients.

If what I have argued so far is correct, then, in the cases in which an act of hard paternalism involves an act of dishonesty it makes little sense to consider only the rationale for autonomy and not the one for trust. To be fair, in other parts of their account Beauchamp and Childress recognize that to be trustworthy is a fundamental virtue for clinicians, and that preserving patient's trust is essential to pursue the ends of medicine. However, these considerations do not seem to do any relevant moral role when it comes to decide whether an act of hard paternalism involving the use of dishonest communication is morally permissible.

In sum, if considerations of respect for patient's autonomy are always crucial, they are not the only ones deserving our attention, and often not even the most important ones in

evaluating whether or not an act of dishonesty is morally permissible. Moreover, taking such a narrow perspective exposes autonomy-based and exceptionalist positions to other two objections: the one of creating a biased “moral perspectivism”, and the one of increasing the suspiciousness toward medical professionals.

(4.3.b) Moral perspectivism

In evaluating the moral permissibility of a deceptive act, autonomy-centered exceptionalist positions run into the risk of adopting a univocal and one-sided moral perspectivism. In fact, what it required on the part of the physicians is just to balance between the prospective health-benefits and the prospective infringement of patient’s autonomy. This methodology, however, does not adequately take into account what, following Bok’s analysis, we have labeled as the “discrepancy of the perspectives”; that is, the tendency to evaluate differently the risks and consequences of an act of deception depending on which of the two perspectives is articulated: the deceiver or the deceived’s one.

Without further qualifications, clinicians adopting the view of “justified hard paternalism” as proposed by Beauchamp and Childress would invariably tend to articulate only *their perspective*. Of course clinicians taking this view should ask themselves what kind of implications would follow from deceptive act for that particular patient. To some extent, then, the circumstances and preferences of the patient are factored in while balancing the reasons behind each possible course of actions and thus before taking the final decision about whether a certain deceptive act is morally permissible. Nevertheless, it is reasonable to presume that in each case patient’s preferences are determined just from the point of view of the clinicians who is evaluating the possibility of being dishonest, and not from the point of view of the patient who will be subjected to deceptive act.

As we have seen in (3.3), this may bias the moral appraisal of a deceptive act at difference level. Even if we consider only the rationale for respecting patient's autonomy, considering only our own perspective could lead us to unwanted consequences, such as to a failure in recognizing that we are acting paternalistically; a biased identification of the reasons supporting our paternalistic act; overlook other truthful non-paternalistic alternatives, and so on. The risk, then, is that the process of moral justification envisioned by these perspectives is, at least in the case of deception, systematically skewed on the perspective of the physicians.

(4.3.c) Arbitrariness and suspiciousness

Another objection to which autonomy-based exceptionalist positions are exposed is that they foster a climate of suspiciousness. Not only these views articulate only the perspective of the clinician, but the doctor is also the only one who knows the final result of each decision-making process. Clinicians who judge that a deceptive act is morally permissible are never compelled to disclose, at any given time, to the patient in question that they have done so for his or her benefits. In other words, not only autonomy-based exceptionalist positions grant to the clinicians the dubious ability of being able to fairly articulate the patient's perspective, but they also grant to clinicians the possibility of keeping such choices perfectly secret. As long as the clinician *judges* that she has acted in an ethical and fair way, she must never reveal the use of deceptive means. Failing to disclose an act of hard paternalistic dishonesty is never a morally problematic. This view, I contend, is problematic for two reasons.

First, it grants to clinicians the best possible conditions for profiting by the "free-rider status" that dishonesty grants to those who take the deceiver's perspective: clinicians are always the *judges*, the *executors*, and those who can *excuse* their own conduct. This condition may introduce several bias in our moral judgments because of the "discrepancy of the perspective".

Secondly, this practice may indirectly foster a climate of lowered trust toward medical professionals. In fact, within this view, there is always the possibility for clinicians to unjustly distort or withhold information relevant for patients.

This suspiciousness may arise because physicians have a *prima facie* duty of veracity and yet are not compelled to disclose whether they plan to, or have already broken, such obligation. Accordingly, there is no way of telling whether a clinician is honest or whether she is systematically breaking her obligation of veracity. In normal contexts, this suspiciousness does not arise because of the minimal trust grounding each the therapeutic relationship. We normally trust that our clinicians will not act too paternalistically and will not harm and exploit us. However, the nature of trust-relationships is essentially diachronic and frail (see next section). Thus, we may normally trust our clinicians, but we would become very suspicious whenever we assume the perspective of the deceived, for example if we uncover that our clinician has prescribed us a inert placebo as if it was an active medication. In this case, interpersonal trust may fall below a minimal threshold, and it is likely to remain so precisely because we are now aware that doctors can decide to deceive us and yet are never compelled to reveal whenever they have made an exception to the duty of veracity.

In these circumstances, this unaccountability may lead to legitimately suspect of clinicians' moral integrity. Since each infringement of the *prima facie* duty of veracity may and is likely to remain secret, then, from the point of view of patients or society, there is no way of telling to what extent physicians are upholding their duties of honesty and, by extension, they wider set of obligations entrenched in their fiduciary pact with patients and society.

(4.4) The limits of trust-based categorical perspectives

The third possibility is to take a trust-based categorical approach. According to this view, the primary concern while we evaluate the morality of a deceptive act concerns the preservation of the bond of trust between doctor and patient (or medicine and society). These perspectives are categorical on precautionary and consequentialist grounds: since they consider trust to be the condition *sine-qua-non* therapeutic relationships exist, and there is always the possibility that even a small act of dishonesty might have catastrophic consequences for trust, then—it is claimed—no act of dishonesty should be permissible. In other words, given its potential consequences for something as fundamental as trust, according to these views we should enforce a categorical ban of all dishonest practices. Limiting the scope of this claim to lies, Jackson has defended precisely this view according to which:

The commitment not to lie is only persuasive and reliable if it is an unqualified and non-discretionary commitment. Anything short of this does not work. Exceptions that are implicit are maybe even more liable to expand and weaken our reliance on the rule. At least if the exception is spelled out there is a possibility that the precedent will be reflected on and that some attempt will be made to fit subsequent exceptions within it. Anyway, whether we do it implicitly or explicitly, when we make an exception we set a precedent (Jackson 2001, 135).

Since each lie sets a “precedent”, in Jackson’s view clinicians should have an absolute moral duty never to lie (though she does not consider problematic deception and concealment!). Notice how this argument explicitly builds upon the previous objection moved to autonomy-based exceptionalist positions: since clinicians must not disclose *when*, *how* and *why* an exception to the rule of veracity has been made, one can never know whether doctors have been honest in their communications; consequently, one can always suspect that clinicians do not respect their duties of veracity (and by extension their other duties), especially those who have been already deceived. Apart from our trust, who can guarantee that physicians are honest if we have no way of knowing when and how they have secretly decided to violate their *prima facie* duty or veracity?

As in the next chapter I will defend a balanced perspective, I share three core assumptions with the view that motivates this interrogative. First, for the reasons that we have seen in (3.2), trust is the pivotal concept for constructing a moral theory of how we should deal with honesty (and dishonesty) in medical settings. Second, trust-based relationships have a frail character: not only those who trust are vulnerable to be betrayed by those who are trusted, but trust, once shuttered, may be hard to restore (see below). Hence, for their own nature, trust-based relationships mandate a cautionary stance.⁵¹ Thirdly, because trust is so fragile, clinician's unilateral discretionality and secrecy in deciding whether an act of dishonesty is justifiable should be regarded as problematic.

Setting aside these points of agreement, however, I argue that trust-based positions supporting a categorical ban are still deeply problematic, partly because they fall into the same kind of criticisms that apply to other categorical positions as well, partly because they overlook the importance of respecting patient's autonomy, and partly because they are premised on a too strong cautionary stance. Like any categorical position they cannot account for situations in which there is a conflict of duties, as in every case similar to the "murderer at the door" example; and they run into the difficulties of establishing the limits of their categorical ban. Aside from these general critiques, categorical trust-based views run also into some more specific criticisms that I address below.

⁵¹ Trusting others is never an entirely rational phenomenon (Baier 1986). For one thing, being in a trust relationship leads the trustor to resist evidence about the immoral conduct of the trustee: if I believe that you are very trustworthy, it might first think that you are late to our appointment for different reasons, and only after a while I might start considering the possibility that you have fled with our money. By contrast, if I openly distrust you—or at least I have a neutral attitude toward your behaviour—I might begin to suspect of your being late even if I do not have any evidence to substantiate my suspiciousness.

(4.4.a) The nature of trust-based relationships

Categorical trust-based positions are grounded on two claims: (i) that trust-based relationships are frail and thus each act of dishonesty will have severe consequences; (ii) and that there are no *non-arbitrary* ways for deciding which exceptions to the duty veracity are justified. Clarifying the meaning of these two claims reveals why categorical trust-based positions are problematic and allows ascertaining what features a better theory should have to avoid the same pitfalls.

(4.4.a.i) The frailty of trust-based relationships

Let us begin by unpacking the first claim, namely that every act of uncovered dishonesty may potentially shatter trust by setting up a precedent. There are two different ways in which this claim can be understood, one stronger and one weaker. The stronger interpretation is that every act of dishonesty will compromise the trust between doctors and patients. Usually, supporters of trust-based positions ground their precautionary positions by underscoring the “frailty” of trust-based relationship.

Unlike other kinds of interpersonal relationships (e.g. love, faith), trust relationships are by all accounts connoted by an intrinsic frailty. By definition, establishing a relationship of trust exposes the trustor to the risk of being betrayed by the trustee. But how severe should be a betrayal as to compromise the bond of trust between the trustor (i.e. the patient) and the trustee (i.e. the doctor)? Consider the following account involving a deceptive placebo:

Now I was brought up, as I suppose every physician is to use placebos, bread pills, water subcutaneously, and other devices for acting upon a patient's symptoms through his mind [...] It never occurred to me until I had given a great many placebos that if they are to be really effective they must deceive the patient [...] But one day a patient caught me in the attempt to put her to sleep by means of a subcutaneous injection of water. “I saw you get that ready,” said she, “and there is no morphine in it; you were just trying to deceive me”. I was fairly caught and there was no use trying to bluff it out, so I merely protested that

my deception was well meant, that it profited me nothing, that I was simply intended to give her a night's rest without the depressing effects of morphia, etc. "Of course I see that", she said, "but how am I to know in future what other tricks you will think it best to play for my good?" How am I to believe anything you say from now on?" I did not know what to answer to make at the time, and I have never been able to think of any since (Cabot 1903, 248).

This quote underscores two crucial points. First, the bond of trust between patient and physician can be shattered even by a trivial episode—in this case the provision of an innocuous and “well-intentioned” placebo. As noted before, sometimes the mere suspiciousness of others’ dishonesty is sufficient to compromise trust, even if the trustor has no evidence or proof of the trustee’s betrayal. Other times, instead, a real betrayal will be discovered, as in the above case of the placebo injection. In both cases, the greater a betrayal is perceived, and the easier it is for it to shatter the bond of trust. In order to preserve an optimal climate of trust, thus, clinicians should not only refrain from being dishonest, but they should also promote trust in a positive sense, upholding a high moral standard to prevent unwarranted suspiciousness. In other words, to preserve and foster the bond of trust with patients, clinicians should be like Caesar’s wife, that is, they “must be above suspicious”.

Secondly, once shattered, trust is hard and sometimes impossible to reconstruct. Trust has a diachronic character, and one case of uncovered dishonesty may lead one to suspect of the moral integrity of other persons, even if those persons are significantly trustworthier than others. Once trust has been disrupted, people become suspicious, and start guessing what the deceiver’s “hidden agenda” might be, thus wondering on how many occasions s/he might have already profited, or will again profit, by our misplaced trust.⁵² Importantly, trust cannot be willed: like disbelief we cannot decide who, when, and what we want to trust (Baier 1986).

⁵² Consider also the following story told by Harris (2013, 21-22) “Jessica recently overheard her friend Lucy telling a white lie: Lucy had a social obligation she wanted to get free of, and Jessica hear her leave a voicemail message for another friend, explaining why their meeting would have to be rescheduled. Lucy’s excuse was entirely fictitious—something involving her child’s being sick—but she lied so effortlessly and persuasively that Jessica was left wondering if she had ever been deceived by Lucy in the past. Now, whenever Lucy cancels a plan, Jessica suspects she might not be telling the truth... Lucy has not reason to think that Jessica has a grievance against her—because she doesn’t. She simply does not trust her as much as she used to, having heard lie without compunction to another friend.”

What does the frailty of trust entail in clinical contexts? For one thing, it entails the adoption of a cautionary stance on the part of the clinician. If trust is a precondition to build a meaningful therapeutic relationship, then physicians must be aware of the frail nature of any trust-based relationship, knowing that one episode of uncovered dishonesty may sometimes be sufficient to compromise the trust in their personal and professional trustworthiness. In this respect, the precautionary worries motivating trust-based positions seem to be justified.

However, from the need to adopt a cautionary stance as to preserve trust whenever possible it does not follow that each deceptive act will irremediably compromise trust, not even in the case in which the deception is ultimately uncovered. There are at least two reasons supporting this view. The first one is that it is possible for someone to actually willing to be deceived, or to entrust others to decide over issue of information provision in her/his place. In these cases, an uncovered deception may not shatter trust as it can instead reinforcing it by showing how much the doctor “understand” and “care” for this patient (see 6.8).

Second, there are countless situations in our lives in which lying, deception and concealment of information are practices but they do not affect our trust toward others. For example, we do not loose our trust in the police if we are stopped by an “undercover” car; we do not loose trust in an actor who dies on the stage but then walks away at the end of the show; we do not loose trust in a magician who pretend to possess magical powers during a performance; and we do not loose trust as we play board games in which part of the game is precisely that of deceiving others about our identity. Thus, it is simply false that any uncovered act of deception would always and irremediably compromise interpersonal trust.

In the next chapter I will argue that what the magician, the police, the actor and the board game scenario have in common is that they are all situations in which the trustor know that the trustee may legitimately resort to deceptive means; accordingly, she can thus

“suspend” her usual judgment over the trustor overall trustworthiness. Furthermore, I will also maintain that such situations are already common in medical settings.

So, which act of dishonesty will endanger individual and public trust in medical professionals? The answer to this question is that it always depends on the context, that is, on *who* trusts *whom* for *what*. As noted by Hardin (2002) “trust is generally a three part relation: A trusts B to do x (or with respect to x)”. Thus I can trust my brother to be well intentioned on my part when we will discuss financial matters even if I know that he is inclined to cheat when we play cards. In this case, I trust someone (my brother) with respect to something specific (be well intentioned on my part while discussing financial matters), even if I know that I should probably not trust him in other contexts (i.e. as we play cards).

Hence, a weaker and more plausible version of the second claim is that only *some* acts of uncovered deception *will* irremediably compromise interpersonal trust. These acts, I proposed, are the ones in which the trustor interpret the act of uncovered deception as a *betrayal* of her trust. Clearly, this is not the case in any of the scenarios presented above. Only in these cases of perceived betrayal, due to the frailty and diachronic character of trust-based relationship, there is a high chance that trust will be compromised. Henceforth, I shall take this narrower version of the first claim as the one that ought to be addressed while evaluating the moral justification of an act of dishonesty in medical contexts.

In sum, the cautionary stance motivating categorical trust-based position partially misconstrue the nature of trust, as it is premised on the false claim that every deceptive act, uncovered or not, might irremediably compromise patient’s trust. Yet, this is not the case in a large class of situations. Therefore, although we should adopt a cautionary stance with respect to the use of deception in clinical contexts, adopting a categorical position on the grounds that every deceptive act will “set a dangerous precedent” seems to be unwarranted.

(4.4.a.ii) Arbitrariness and suspiciousness reloaded

The second claim, which also is decisive in justifying categorical trust-based views, is that each exception may potentially “set a dangerous precedent” for trust because it is decided in an *ad hoc*, arbitrary, way. It is the arbitrariness in the process whereby exceptions are decided what justifies on the part of the patient a legitimate suspiciousness as to the real motivations behind each dishonest act:

Is there a third way [between categorical ban and no ban at all]? A possibility here is to seek to soften the simple absolute rule against lying by incorporating some exceptions into the rule. The resultant rule would still be absolute, but less simple. However, we run into difficulties if we try to soften the strict rule against lying: how to do so without inviting further erosion; how to draw a firm but non-arbitrary line between defensible and indefensible lying? [...] Once we start writing in exceptions there seem no firm barrier to our tacking on further ones as need arises. But a firm barrier is needed—or else trust in each other’s word becomes impossible (Jackson 2001, 133).

In this quote, Jackson notes that, at least theoretically, there is a third way that could avoid the problem of any extreme position regarding the moral justification of dishonesty in clinical settings: to elaborate a non-arbitrary rule for deciding which exceptions to the duty of veracity are or not legitimate. If such rule could be found, that it would be possible to have both permissible exceptions to the categorical ban of dishonesty—thus avoiding its many pitfalls— *and* to generally preserve the trust of the public and of individual patients in those who have resorted to situational dishonesty—since their decisions would have depended on the occurrence of the right circumstances rather than on a mere calculus that could have been biased for their own selfish interest. Clearly this non-arbitrary rule is currently not in place in contemporary clinical settings, where most (if not all) of the decisions regarding the use of dishonest practices are taken by single clinicians, that is, in a semi-arbitrary way.

In other words, the problem of individuating a principle that might theoretically allow for justified exceptions to the duty of veracity is necessarily interwoven with the problem of keeping the decision of clinicians about such exceptional cases secret and thus unaccountable.

But even if such rule could be found, then it would be still valid the other part of the objection that points at the legitimate suspiciousness that patients and the public may harbor concerning the *ad hoc* judgment of the single clinician. Siding with this latter argument, I agree that any trust-based view that allows for exceptions to the rule of veracity ought to meet these two intertwined challenges, thus indicating how exceptional cases can be distinguished from those in which we should stand firm by the duty of veracity; and how it is possible to preserve trust in the light of the secrecy that current practices entail. Differently from Jackson, however, I do not think that these two challenges are impossible to meet. Indeed, as I will explain in the next chapter, it is possible to avoid the pitfalls of categorical perspectives without compromising the bond of trust between doctors and patients.

(4) Summary

In this chapter I have analyzed some of the major accounts that have been proposed to deal with the moral implications of dishonesty in medicine. After distinguishing between trust-based, autonomy-based and balanced views, and between categorical and exceptionalist positions, I have argued that categorical positions based on trust and autonomy as well as autonomy-based exceptionalist positions lead to unwanted or counterintuitive consequences, and are therefore inadequate. All categorical positions face the decisive criticism that in medical contexts clinicians seem to face genuine moral dilemmas involving a conflict between veracity and other obligations, usually beneficence and nonmaleficence. Furthermore, these views have troubles in specifying a limit to their categorical ban: if the ban is extended to deception, then it leads into counterintuitive conclusions; if it is limited to lies, then it provides an unsatisfactory way of thinking about some of the features of dishonesty.

Then, I have criticized the autonomy-based exceptionalist view elaborated by Beauchamp and Childress, arguing that it does not take into adequate consideration some of

the core features characterizing the moral phenomenon of dishonesty. According to the view elaborated by Beauchamp and Childress, to decide whether an act of hard paternalism is justified we should balance considerations of autonomy against consideration of beneficence and nonmaleficence. As I have argued, this perspective is useful whenever we are considering cases of hard paternalism in which the only moral issue at stake regards the infringement of patient's autonomy—as for example in the case of the mandatory law to wearing seatbelts or in the case of the patient refusing the side rails. However, the same perspective is problematic when it is applied to cases of hard paternalism that involves dishonesty in communication: lies are not seatbelts, and resorting to dishonesty entails something more than just infringing on other's autonomy, that is, short and long term effects on trust. Yet, these possible implications for trust are not factored in Beauchamp and Childress's account, thereby leading into two further problems: the one of “moral perspectivism”, and the one of “arbitrariness”.

Finally, I have criticized trust-based categorical positions, arguing that they partially misconstrue the phenomenon of trust. While these positions rightly identify in the preservation of the bond of trust between doctor and physician a key moral issue pertaining to the use of dishonesty in clinical settings, the premises on which they ground their categorical perspective are either clearly false or dubious. First, it is not true that every act of uncovered dishonesty will endanger interpersonal trust, as trust-relationships are usually quite specific. Not every uncovered act of dishonesty will threaten interpersonal trust, and consequently the cautionary stance taken by these positions is unwarranted. Second, it may not be true that a rule that allows exceptions to clinicians' duty of veracity will necessary compromise patient's trust; as I will show in the next chapter, it is possible to avoid both the pitfalls of categorical positions while at the same time devising a way of preserving patient's trust and autonomy.

5. Deception and Public Justification

Truth is beautiful, without doubt; but so are lies.

Ralph Waldo Emerson

Every truth has two sides; it is as well to look at both, before we commit ourselves to either.

Aesop

(5) Introduction

In this chapter I advance my proposal that deception in clinical settings is ethically justifiable in exceptional cases, provided that the following conditions are met: (i) that other plausible courses of truthful action have been ruled out; (ii) that the proponent would be ready to defend her conduct in public; (iii) that the deceptive act is publicly disclosed. Whenever these conditions are in place, I will argue, benevolent deception may be morally permissible. This chapter is divided in four parts. First, I shall briefly recapitulate the main argument. Then, I shall articulate my solution based on three procedural conditions named (i) the test of veracity, (ii) the test of hypothetical publicity, (iii) and the test of public disclosure. Thirdly, I will show how this perspective can be translated into a decisional flowchart for guiding clinical decision-making. Finally, I shall consider the main advantages of my account.

(5.1) Summary of the main argument

Clinicians' obligation to tell patients the truth is a recent addition to medical ethics. Traditionally, medicine has been grounded solely on the principles of beneficence and non-maleficence. In the last fifty years, however, the rise of autonomy in biomedical ethics as well as other societal changes have brought to the fore the necessity of incorporating rules of veracity within professional codes and ethical guidelines. Accordingly, today it is widely accepted that clinicians have a duty of veracity toward their patients. In medical ethics, this duty is often conceptualized as a *prima facie* duty, that is, as a duty that is morally binding unless there are compelling reasons to do otherwise. *Prima facie* duties establish a default attitude, but allow for qualified exceptions whether the right circumstances obtain.

In order to identify those exceptions, however, one needs to specify the extension of the obligation of veracity. I have thus proposed to conceptualize clinicians' *prima facie* duty of

veracity as the conjunction of two complementary *prima facie* obligations: the negative “duty of truthfulness” and the positive “duty to inform” patients. Building on this distinction, dishonesty in professional communication has been further defined in the terms of the ways in which clinicians can violate these two obligations. This has led to distinguish the concepts of lying, deception, and keeping someone in the dark. Importantly, within this theoretical framework, one can deceive others by action as well as by omission, and even by remaining silent or by telling the truth; it is also possible to be dishonest without deceiving others, but merely by failing to provide all the relevant information required by the duty to inform.

Next, I have looked into the reasons why dishonesty is *prima facie* unethical in clinical medicine, identifying two main rationales. The first rationale concerns the respect of patient’s autonomy. Lying and deceit prevent patients from forming their own views and thus to decide and act autonomously. Consequently, dishonesty is *prima facie* unethical because it disrespects patient’s autonomy. The second rationale, then, is that dishonesty threatens the bond of trust between clinicians and patient. Patients and clinicians are brought into a relationship because of a fiduciary pact. This pact establishes a reciprocal set of rights and duties whereby society entrusts medical professionals with power and authority provided they abide to certain standards of competence and morality. Dishonesty undermines the trustworthiness of clinicians, hence jeopardizing the bond of trust between patient and doctors and the *bona fide* in medical professionals. Consequently, dishonesty is *prima facie* unethical because it threatens an essential precondition for having meaningful clinical relationships.

I have then argued that each of these rationales may provide a compelling and independent reason to support the view that veracity should be clinicians’ default attitude in clinical settings. However, while respecting patient’s autonomy is always a necessary condition for having an ethical clinical relationship, the preservation of the bond of trust between doctor and patients is often a necessary *and* a sufficient condition for achieving such an end. In fact, not every clinical relationship occurs between two competent and autonomous agents, and

without trust clinicians cannot in any case adequately foster patient's autonomy. Finally, elaborating on Bok's analysis, I discussed how dishonest acts must be always evaluated by articulating both the perspective of the duper and the perspective of the duped, thus taking into account the moral phenomenon of the "discrepancy of the perspectives".

Next, I have analyzed other accounts that have been elaborated in medical ethics to deal with the moral implications of benevolent deception, noting their limitations. I have thus distinguished first between "autonomy-based", "trust-based", and "balanced" positions, and then between "categorical" and "exceptionalist" views. Categorical positions are problematic because considerations of compassion and beneficence may sometimes override the duty of veracity; and because it is impossible to specify the limits of a categorical ban of dishonesty without falling into false or counterintuitive conclusions.

Exceptionalist autonomy-based positions—like Beauchamp and Childress's "justified hard paternalism"—, instead, overemphasize autonomy over trust, and thus do not take into adequate consideration the implications that dishonesty may have for the doctor-patient relationship, an issue which is particularly severe because of the secrecy that these views allow to clinicians.

Lastly, categorical positions based on trust capture most of the features of trust-based relationships, including their frail nature. However—and aside for underestimating the importance of respecting patient's autonomy—, these views are based on two problematic assumptions, namely: that every act of uncovered dishonesty will compromise trust; and that it is impossible to identify possible exceptions to the duty of veracity in non-arbitrary ways. The first of this assumptions, I argued, is based on a partial misconception of how trust-based relationship operate, while the second stands still in need of a reply, to the elaboration of which the rest of this chapter is hereafter devoted.

(5.2) The proposed solution: deception and public justification

Based on the previous analysis, a satisfactory exceptionalist view of dishonesty in clinical contexts should possess at least two features. First, it must be able to take into adequate account the consequences that benevolent deception may have for both patient's autonomy and trust. Any theory that does not take into adequate account both rationales is likely to overemphasize one aspect over the other, and thus to be biased under that respect.

The second feature, then, flows from the fact that those who deceive and those who are deceived tend to appraise the same scenario from different perspectives. Accordingly, the evaluation of the risks, costs and moral implications of each of deception may be biased whether we articulate it from only one of the two possible perspectives. In clinical contexts this discrepancy is further reinforced by the power-asymmetry entrenched in any therapeutic relationship and by the possibility for clinicians to act in complete secrecy, and by the frail nature of trust-based relationships which means that even a small breach of patient's trust may result in irreparable consequences. Any theory that allows exceptions to the duty of veracity must also explain how it rules out or minimizes the risks for interpersonal and social trust that may arise from permitting the use of benevolent deception.

To meet these requirements, the account that I will propose is based on the concept of "publicity". According to this view, each deceptive act requires a moral justification. However, in order to be admissible, this moral justification must meet two demanding criteria: first, those who are supporting it must be prepared to defend their reasons in public; second, every exception that will be (or has been) made must also be publicly disclosed. Clearly, the practical import of these two criteria depends on the meaning of the term "public"—or, as we shall see, of the term "publicity". To unpack this crucial point, in this chapter I articulate my proposal in the terms of a three tier-process whereby clinicians can formulate adequate moral justifications to defend the exceptional use of benevolent deception in clinical contexts. This

process is arranged in three steps, namely, (i) the test of veracity; (ii) the test of publicity; (iii) and the test of disclosure. Whenever a moral justification for using benevolent deception successfully passes these three tests then, I argue, such an act may also be morally permissible.

(5.3) The principle and the test of veracity

According to Aristotle, “Falsehood is in itself bad and blameworthy, while the truth is noble and praiseworthy” (2000, 76). Lies, deception and misleading concealment are in themselves “blameworthy” because they always exploit others’ trust, disrespect their individual autonomy, and lead to unwanted consequences for both the deceivers and the deceived. By contrast, the truth is “noble and full of praise” because telling the truth enables social and interpersonal cooperation, reinforces trust, and allows others to become fully autonomous agents.

For these reasons, falsehood is *prima facie* morally wrong while truthfulness is *prima facie* morally right. Other things being equal, truthfulness should be our default attitude in communication, while lying and deception should instead be avoided and blamed. The same is true, of course, of the attitudes that other speakers should have while communicating with us. Social cooperation is based on mutual trust, and mutual trust is partially grounded on the belief that usually the behavior of others will conform will be predictable to some extent because it will conform to certain shared rules. The reverse is true with lies and deception. In most of the cases we are not prepared to take the perspective of the deceived, and this is why, once we learn that we have been duped, we are first surprised and then upset. Hence there is a structural imbalance in the way in which we appraise truthfulness and falsehood: the former is “noble and full or praise”, while the latter is always “mean and culpable”.

Acknowledging this fundamental difference in our moral attitudes toward truthfulness and falsehood, Bok (1978) has proposed to adopt what she defined as the

“principle of veracity”. This principle stipulates that there is “an initial imbalance in the evaluation of truth-telling and lying. Lying requires a *reason*, while truth telling does not. It must be excused; reasons must be produced, in any one case, to show why a particular lie is not “mean and culpable” (Bok 1978, 22). According to this principle, there is a fundamental difference between honesty and dishonesty: while normally the former does not require the provision of a moral justification, the latter, instead, always does.

Bok’s “principle of veracity” shares profound similarities with the Rossian view that clinicians have a *prima facie* duty of veracity. Both the principle and the *prima facie* duty of veracity are grounded on the recognition that there is a structural imbalance between truthfulness and falsehood. Furthermore, they both specify this imbalance as a difference at the level of moral reasons-giving: truthfulness does not require an excuse, while falsehood always stands in need of a justification.

A first important corollary of this view is that, unless there are compelling reasons to act otherwise, we should always prefer truthful courses of action to deceptive ones. Other things being equal, if we can achieve our objectives without resorting to deception we must do so. Falsehood is always *prima facie* “mean and culpable”, but it is even the more so when it is redundant, superfluous and gratuitous. Thus, before considering whether an act of deception is morally justifiable, we should first determine whether such an act is necessary to achieve our objectives. This implies that deception can be morally justifiable if and only if other truthful courses of action have been already identified and ruled out.

But who should, in any one case, conduct this process of evaluation whereby all other plausible and truthful courses of action are identified and eventually discarded in favor of deception? Given that deception is often a matter of secrecy and concealment, the answer to this question cannot be but “the deceiver”. In each case, the burden of demonstrating that a departure from the duty of telling the truth is required should fall on those who propose,

enact and will possibly profit by such a departure. They are the ones who must demonstrate that, among all other plausible alternatives, in these specific circumstances deception is the best plausible means to achieve the desired objective.

Meeting this precondition requires, on the part of those who are proposing the deception, at least the active effort of searching for other plausible courses of action, as well as the capacities for appraising how well each of them would achieve the desired objective. Thus, the moral justification of an act of deception stands or falls with the ability of the deceivers to argue that such act was necessary rather than a matter of selfish convenience.

Therefore, any clinician who is pondering if an act of deception is morally justifiable must first answer the following question: “Would you be able to argue that deception is the only plausible means to achieve your objective?”. If the answer to this question is affirmative, then the process of moral evaluation may continue to the stage at which the reasons in support and against the proposed deceptive act are weighted one against the other. If, instead, the answer to this question is negative, then the considered act of deception is unjustifiable because there is no compelling reason to override the *prima facie* duty of veracity.

Henceforth I shall refer to this preliminary check-question as the “test of veracity” (or TOV, for short). In my account The TOV serves a twofold function. First, it encapsulates the principle that, other things being equal, we should always prefer truthful courses of action to deceptive ones; second, it makes explicit that, in any one case in which a deceptive act is morally judged, the burden of proof for demonstrating the lack of other plausible and truthful alternatives should fall on those who are proposing or have already enacted it.

Importantly, the TOV does not entail that every deceptive act is unethical. Rather, it only underscores that truthful courses of action are generally preferable to deceptive ones, and therefore that whoever resorts to deception must also provide *some reasons* for not abiding to

the default attitude of veracity. Likewise, *prima facie* duties indicate what our default attitude should be, but admit that one can act otherwise whenever there are overriding *reasons* for doing so. In the next section we shall explore more in depth what kind of reasons one must provide in order to defend benevolent deception in a satisfactory way.

(5.4) Justifying deception: the test of publicity

The test of veracity rules out dishonest acts that are unjustifiable because superfluous: other things being equal we should prefer truthful courses of actions. There are cases, however, in which deception is the only plausible option. Consider the example of an empirical study through which a team of psychologists aim at studying people's cheating attitudes in cooperative scenarios. If the study participants were aware that the researchers are observing their cooperative attitudes they will alter their behaviour accordingly, hence biasing the study. Thus, in order to investigate such attitudes, the researchers must deceive the participants about the true scope of the study—for example by temporarily concealing the purpose of the tasks that the subjects are required to take. In this case, resorting to deception is the only plausible means through which the researchers can achieve their objective.

Passing the TOV, however, is not sufficient for a dishonest act to be morally justified. The fact that human extinction may be the most effective means to solve the problem of human hunger does not make it something morally permissible or praiseworthy *per se*. Something can be a perfect means to achieve an end and be morally blameworthy at the same time. Therefore, once a proposed act of deception has passed the TOV, those advocating it must still defend their proposal by providing their reasons in its favour. This second step inevitably implies a trade-off between the reasons supporting the case for deception and those against it. Since falsehood is always “mean and culpable” those proposing a deceptive act must

show, in any one case, that the moral goods that it will conceivably allow to achieve will eventually outweigh its drawbacks.

Usually, the identification and the weighting of these reasons in support and against an act of deception are left to the private judgment of those who are proposing the deceptive act. This is the case, for example, of the account proposed by Beauchamp and Childress (2009) for which it is usually the clinician who propose the deception the one who articulates the reasons pros and cons it, and the one who eventually decides what ought to be done in each case. A major problem with this view is that any decision of this sort is likely to be biased. In fact, the ones who conduct this evaluation are also the ones proposing the deception to meet their objectives. This introduces a structural bias in the evaluation of the arguments in favour or against deception due to our tendency of articulating skewed perspectives (see 3.3).

In the example above, the balancing of the reasons pros and cons the use of a deceptive trial-design will be carried out by the researchers proposing it. Inevitably, the researchers will tend to articulate their perspective, that is, the one of those needing deceptive means for achieving their objective (i.e., obtaining valid data). In this case, as we will see, the risk of arbitrariness is partially controlled (but not eliminated) by the needs to submit a formal application to the ethical committee or IRB, and to obtain a valid informed consent (or a delayed consent) from the study participants. Yet, in contexts in which the duper can evaluate the various practical and moral implications of dishonesty in full secrecy, the risks of carrying out a skewed evaluation become exponentially greater. Unfortunately, this latter scenario is the most likely to occur in clinical settings, where a clinician can and will often decide in semi-arbitrary ways whether a proposed act of dishonesty is or not morally permissible.

Therefore, the discrepancy of the perspectives raises a genuine conundrum for anyone evaluating the use of deceptive means: in order to justify an act of deception one must evaluate whether its pros outweigh its cons; yet, due to the “discrepancy of the perspectives”,

such moral evaluation is likely to be systematically biased. To resolve this difficulty I propose to adopt the view that any valid moral justification for an act of deception requires the provisions of adequate reasons in its support; and that these reasons are adequate if and only if other reasonable persons and those who will be deceived could agree with them. On this view, moral justification is thus essentially a process of public reason-giving. As Hume noted, someone seeking moral justifications must “depart from his private and particular situation and must choose a point of view common to him with other; he must move some universal principle of the human frame and touch a string to which all mankind have an accord and symphony” (1948, 252).⁵³

Sissela Bok (1978) has further developed this position, arguing that a moral justification for a lie is adequate only if it could conceivably withstand an ideal process of public justification. Thus, an act of dishonesty is justifiable only if everyone could in principle consider it to be so—including the ones that will be eventually deceived. The idea behind this view is that, if the reasons supporting or opposing a given act of deception were articulated and evaluated from a “public” point of view, then it would be possible to both *include* and *even out* the biases introduced by the partial perspectives of the duper and of the duped, thus providing a fairer basis for taking moral decisions.⁵⁴ In Bok’s words, we should thus

combine [the] concept of *publicity* with the view of justification in ethics as being *directed to reasonable persons*, in order to formulate a workable test for looking at concrete moral choice. It will be a test to weigh the various excuses advanced for disputed choices, and therefore for lies. Such a test counters the self-deception and bias inherent in the liar’s perspective. It challenges privately held assumptions and hasty calculations. It requires clear and understandable formulation of the arguments used to defend the lie—arguments which might otherwise have remained inchoate or seemed intuitively right without ever being questioned. Its advantages, moreover, are cumulative: the objectivity and ability to shift perspectives gained in each appeal to publicity carry over to subsequent ones. Basically, it is through the exercise of such appeals and the debate they engender that a more finely tuned moral sense will develop (1978, 91-93).

⁵³ Similarly, Rawls argued that the process of moral justification “presumes a clash of views between persons or within one person, and seeks to convince others, or ourselves, of the principles upon which our claims and judgments are founded. Being designed to reconcile by reason, justification proceeds from what all parties to the discussion hold in common” (1999, 54).

⁵⁴ “The test of publicity asks which lies, if any, would survive the appeal for justification to reasonable persons” (Bok 1978, 93).

How is it possible, in practice, for clinicians to move from their private perspective to the articulation of public reasons that could withstand the judgment of other reasonable persons? What steps need to be taken in order to craft a moral justification that avoids the structural biases introduced by the “discrepancy of the perspectives”? Extending Bok’s proposal, I will contend that there are four different levels of “publicity” that must be taken into consideration while evaluating the moral permissibility of deception in clinical settings. These levels are the ones of (a) clinician’s private consciousness; (b) the community of peers; (c) the public of reasonable persons; (d) and the perspective of the deceived. We shall now proceed to see how a method structured around these levels operates, and how effective it can be in controlling the biases entrenched in any particular perspective.

(5.4.a) The first level of publicity: self-reflection and the balancing of the reasons

The first level of publicity is the one of the private consciousness of the deceivers. Usually, this is the only level considered by other accounts. At this stage, those proposing the act of deception ought to identify the sets of reasons in favour and against it, ascertaining which one eventually outweighs the other. While each case is unique, there are at least three sets of reasons that must always be considered whenever we evaluate the morality of a deceptive act.

First, there are those reasons that might be cited in favour of the proposed deceptive act. Since the test of publicity (henceforth, TOP) should follow the test of veracity, the case for deception can always count on at least one favourable reason: namely, that deception is the best means for achieving the desired end. There are, however, several other reasons for which one might resort to situational dishonesty. In clinical contexts, there might be, first and foremost, reasons of beneficence and nonmaleficence: deception can sometimes be required to avoid causing suffering; to prevent an emotional, psychological or physical trauma; or for

preserving hope. Deception can also be necessary to preserve patient's long-term autonomy, as when clinicians conceal grim news to avoid a potentially fatal heart attack. There might be also considerations of justice, as sometimes a lie can be the most cost-effective way of achieving an end, for example for making diagnosis that would otherwise requires too expensive equipment. In research contexts, instead, deception may be necessary to obtain valid data.⁵⁵

Second, there are the reasons against the use of deception. As I have argued (see 3.2), there are at least two considerations that must be always taken into account while pondering the use of dishonesty: the respect of other's autonomy and the preservation of trust. These two rationales may independently provide a compelling reason to reject a proposed deceptive act and therefore ought to be considered in every case. It is important to note, however, that while these two aspects are always crucial, they are not the only ones that must be considered. Resorting to dishonesty in clinical settings may raise additional concerns that might include, but are not limited to, the evaluation of the practical consequences, the breach of oaths and promises, the infringement of criminal law, and the possible moral corruption that may derive from lying and deception.

Third, one must also consider the features of the deceptive act. Deception, like any other means, may either succeed or fail. Given the bad consequences that follow when deception is uncovered, deceivers should proceed only if they are reasonably sure that they will succeed in their deception. To this end, one must consider both the short and the long-term perspective: as St. Augustine noted, lies tend to produce a slippery slope in which in order to "shore up" previous lies one needs to lie even more. This creates a self-reinforcing vicious circle for which, on the one hand, one gets progressively accustomed to lying while, on the other hand, the chances of being discovered as well as the severity of the consequences

⁵⁵ In some cases dishonesty may be motivated by purely selfish reasons, as when clinicians mollify anxious patients with the only intent of getting rid of them; on this issue see (6.9.c).

increase. Finally, among all the plausible deceptive acts, some may be less desirable than others (Sokol 2007). As I argued in (2.3), there is no intrinsic moral difference between lying, deceit and malicious concealment, as their moral weigh is context and audience-sensitive. However, in most of the cases people tend to consider an open lie as being more blameworthy than an elusive answer. Thus, between two plausible and equally effective deceptive acts, one should select the one that is likely to be perceived as being less blameworthy. Other things being equal, deception and concealment are thus preferable to openly stated lies.

Once these aspects have been considered, the sets of reasons in favour and against the deceptive act must be weighed one against the other. If the reasons in favour outweigh those against it, then the proposed act of deception is morally justifiable. While this methodology is sound, if conducted only at the level of the private consciousness of those proposing the deception it is likely to be biased under two respects.

For one thing, one may simply fail to identify all the relevant reasons that are pertinent to each case. Most physicians are still not properly trained in dealing with moral dilemmas, let alone with other technical distinctions as the one between lying, deception and concealment. Also, the calculus of the potential consequences and the determination of the least problematic verbal formulation to be used may require both cognitive resources and a creativity that not everyone may possess. In other words, a fair identification and judgment of all the relevant reasons pros and cons a given act of deception may be a practically demanding task for which individual resources may be insufficient. Moral judgments, like any judgment taken by less than perfectly rational agents, are intrinsically fallible (Ross 1930).

More importantly, the final judgment may be structurally biased due to the “discrepancy of the perspectives”. Deceivers tend to systematically discount the long-term risks of deception in favour of their short-term gains. They tend to articulate only their own

perspective, including all the reasons in their favour while excluding those concerning the consequences for the deceived. Also, deceivers tend to cover selfish motives of action by disguising them under altruistic justifications—often through semi-unconscious self-deception.

In sum, an act of deception may be morally permissible if and only if it meets at least two preliminary conditions. First, it must pass the test of veracity, and thus it should arguably be the best plausible means to achieve a goal. Second, the reasons in favour of the deceptive act must outweigh those contrary to it. While these two conditions are always necessary, however, they can never be sufficient: in order to reach a fair moral judgment about whether a deceptive act is or not morally permissible other steps have to be implemented as to control for the structural biases introduced by the presence of the discrepancy of the perspectives and to reduce the margin of error which is due to the intrinsic fallibility of our moral judgments.

(5.4.b) The second level of publicity: the community of peers

The second level of publicity is the one of the active confrontation with the community of peers. While each clinical encounter is unique, doctors tend to face a number of situations that are fairly typical across all clinical contexts. For example, working in an oncological facility would likely expose a clinician to a set of more or less similar situations, from the disclosure of grim diagnostic news to the need of preserving hope in terminal patients. But even if one has never encountered a scenario similar to the one at hand, other colleagues, peers and professionals, might have. The pooled experience of the whole community of medical professionals clearly exceeds the one of any of its individual members. This collective experience may serve as an ideal basis to refine, complement, or revise the evaluation of the reasons that has been conducted only on a self-reflective plane of analysis.

Thus, the second level of publicity demands that we further articulate our reasons in favour or against the deceptive act in the light of what others peers would say (or have said) about it. Depending on the circumstances, reaching this second level may entail different practices, which can be more or less demanding in terms of time and resources. For example, a clinician may actually consult other more experienced or trusted colleagues, asking for their feedbacks on the case at hand. Another possibility is to look into the available literature in medical journals, including the ones in medical ethics, looking for ethical analyses of similar cases. A third option might be to contact a clinical ethicist or to reach out for some member of the ethical committee. In any one case, the form of the selected practices may vary, but the goal is the same: challenging our private assessment of the case by looking at how it would withstand the criticism of others sharing our professional experience and perspective.

How can we be sure that our reasons are sufficiently refined to withstand peer's criticisms? In the view that Bok (1978), Sokol (2007), and I endorse, clinicians can take a simple mental test: the "test of publicity". This test demands that those proposing the deceptive act must ask themselves whether they would be ready to defend their choice in front of their peers. Ethics committees and internal audit commissions provide viable examples of this kind of like-minded, epistocratic juries. Would the clinician be ready to defend her choice of resorting to deception in front of such commissions? Would the clinician be ready to argue that she resorted to deception only for the benefit of the patient? Would the clinician be ready to take full responsibility for pursuing such an act, hence accepting all the consequences that might follow whether the commission judges this act to be unjustified?

Here there are three important things to note. First, like the TOV, also the TOP makes explicit that the *burden* and the *responsibility* for justifying any act of deception falls on those proposing it. Sure, it is still a matter of the personal judgment whether one has sufficiently articulated the reasons pros and cons a deceptive act. However, by taking the TOP one is at least forced to re-appraise the strength of her position; if one concludes that she will

not be ready to publicly defend her choice in front of her peers, this may indicate that the proposed act is either not morally permissible *per se*, or that the reasons in its favour ought to be better articulated.

Second, by leading clinicians to articulate their reasons from the point of how they could withstand the criticism of peers, this simple test may aid in screening out those acts of proposed deception that might have passed the first level of publicity but that, upon further reflection, appear to be unjustifiable. In particular, the TOP is likely to reveal which acts can be convincingly defended as to be for the patient's benefit, and those that are instead motivated only by selfish reasons (consciously endorsed or not). Who would be ready to claim, in front of a disciplinary commission, that it was morally defensible to lie about one's having a degree in medicine simply to "reassure the patient"?

Third, taking the TOP may aid clinicians in refining their argumentations. Confronting how other cases have been previously justified may lead to reassess one's own justifications by ruling out fallacious arguments, clarifying the terms that were previously ambiguous, and identifying those reasons pro and cons that have been overlooked. Therefore, taking the TOP may lower the demandingness of taking fair moral assessments alone, hence mitigating the problem of the intrinsic fallibility of our individual (moral) judgments.

At this level, however, the TOP still does not solve the problem of the discrepant perspectives. Confronting our motives of action against those of other colleagues may aid in distinguishing whether we are resorting to deception only for selfish interests.⁵⁶ Nonetheless, even the viewpoint of all the relevant experts may be collectively biased on sectarian grounds. Communities composed of peers tend to excuse rather than condemn the behaviour of their members. Being "peers" means sharing the same perspective, and this may lead to biased

⁵⁶ However, in other cases the boundary between selfishness and benevolence may be blurred, or both can be simultaneously in place. For example, the researchers in the above example can aim both at promoting their career and, at the same time, at extending collective scientific knowledge about cooperative attitudes.

judgments in which the morality of an act is judged on the plane of “us” versus “others”, rather than on the plan of “good” versus “bad”.⁵⁷ For instance, medical professionals have long argued in favour of their exclusive privilege of resorting to practices of benevolent deception, hence defending their “free-rider” status: patients had to be absolutely truthful with their clinicians, but clinicians were instead free to invoke their “therapeutic privilege”.

Therefore, while at this second level of publicity the TOP may aid in mitigating some of the issues of a standard, self-reflective processes of moral decision-making, it still cannot fully control for the structural biases introduced by the discrepancy of the perspective. The fact that a given community has always adhered to certain ethical standards and norms of conduct does not imply that such standards and norms are either right in themselves or appropriate for all cultural contexts.

(5.4.c) The third level of publicity: consistency and the public of reasonable persons

The third level of publicity is the one at which the evaluation of the reasons for the proposed deceptive act are tested against the possible criticisms of a public from which no reasonable person is in principle excluded. At the most general level, this public includes not just the clinician’s peers and other experts but potentially every *reasonable person*, that is to say, anyone who has can partake in the game of “giving and asking” for rational reasons. Thus, the third

⁵⁷ Janis has noted how decisions about foreign policies may be biased due to the way in which they are internally elaborated by a community of like-minded peers: “The members’ firm belief in the inherent morality of their group and their use of undifferentiated negative stereotypes of opponents enable them to minimize decision conflicts between ethical values and expediency, especially when they are inclined to resort to violence. The shared belief that “we are a wise and good group” inclines them to use group concurrence as a major criterion to judge the morality as well as the efficiency of any policy under discussion. “Since our group’s objectives are good”, the member feel, “any means we decide to use must be good”. This shared assumption helps the members avoid feelings of shame or guilt about decisions that may violate their personal code of ethical behaviour. Negative stereotypes of the enemy enhance their sense of moral righteousness as well as their pride in the lofty mission of the ingroup” (*Victims and Groupthink*, Boston: Houghton Mifflin, 1972, 204; quoted in Bok 1978, 97).

level of publicity demands that we articulate our case by taking into account how other rational persons who do not share our sectarian perspective could object to it.

How can we articulate our reasons to control for the potential bias introduced by our belonging to a certain community of like-minded people? How can we appraise the limits of our moral judgments as they are articulated only from a self-interested point of view? Throughout the history of mankind, and more recently throughout that of Western philosophy, this problem has always received a strikingly similar solution: “One should treat others as one would like others to treat oneself”. This maxim, which is known as the “Golden Rule” of reciprocity, requires us to appraise the consequences of our actions by assuming the perspective of those who will be subjected to them. The Golden Rule is often used to judge what we ought to do to benefit others and to do good. However, there exists also a negative and cautionary form—sometimes known as the “Silver Rule” and dated back to the Confucian tradition—, which states, “One should not treat others in ways that one would not like to be treated”. As Al-Ghazali noted with respect to the specific problem of lying to others:

If you want to know the foulness of lying for yourself, consider the lying of someone else and how you shun it and despise the man who lies and regard his communication as foul. Do the same with regard to all your own vices, for you do not realize the foulness of your vices from your own case, but from someone else’s (quoted in Bok 1978, 29).

Practicing the Silver Rule allows to control for the bias entrenched in our sectarian perspective by forcing us to appraise whether we are prepared to be consistent in our moral judgments. Consistency refers here to the combination of two conditions (Carson 2010, 130-131). The first condition is that whenever moral judgments we make must be consistent with the judgments we make about relevantly similar case: our moral judgments should in principle be universalizable. So, if we think that action A is good, and action B is identical under any morally relevant respect to A, then we should conclude that also action B is good. The second condition is that our attitudes and actions must be consistent with the moral judgment we

make. To further explain the relationship between moral consistency and the application of the Golden Rule, Carson (2010, 135) uses the following example:

I am a plumber and often lie to my customers—I claim that they need expensive repairs when they do not. I claim that it is morally right for me to do this. Yet, I object very strongly when I discover that my auto mechanic lies to me and claims that I need a \$2000 engine overhaul when, in fact, I only need a \$200 tune-up. On the face of it, there is no morally relevant difference between what I do and what my mechanic does. To be consistent, I must either (1) change my moral judgment about my own lying and say that it is wrong for me to lie to my customers, or (2) change my *judgment and attitudes* about what the mechanic does to me, and hold that his lying to me about my engine is morally permissible and not longer resent it or object to it.

Siding with Carson's analysis, I understand the third level of publicity as the level at which through the Silver Rule we check the consistency of our moral judgments about a deceptive act. In this view, the appeal to the reasonableness of the public serves a double function: to withstand the criticism of other reasonable persons we should not only provide logically valid argumentations (e.g., by avoiding logical fallacies), but we should also be ready to admit that we will consider these reasons to be 'reasonable' even if we were the target of the proposed action. The appeal to the 'reasonableness' of the public thus provides both the formal condition (logical validity) for any reason that will enter into our argumentation as well as a criterion to judge those argumentations (moral consistency).

Differently from both Carson and Bok, however, I stress that in clinical contexts the condition of moral consistency is not entirely adequate and sometimes self-defeating without further qualifications. By practicing the Silver Rule, in fact, we might introduce another potential bias in our moral evaluation because we substitute the perspective of the patient with our evaluation of what *we*, as patient, would think about that specific deceptive act. However, reasonable people might ostensibly disagree about issue of values—especially whether they touch bioethical issues such as abortion, end-of-life questions, GMOs, animal experimentation, etc. (Boniolo 2012; Boniolo and DiFiore 2010; Boniolo and Maugeri 2014).

Even if we are consistent in our moral judgments, there is always the possibility that other reasonable people would disagree with us.

Recall, for example, the historical shift in the public attitudes toward truth telling discussed in (1.1). In the last thirty years, people's attitudes have dramatically changed, with the vast majority of patients now preferring to be told the truth—even in those cases in which the truth to be disclosed is bad. For a certain time, clinicians who have been trained before that shift had to face the new sensibility of the public for individual autonomy. Reasonable doctors had to face reasonable patients who could have had entirely different attitudes toward truth telling in medicine, hence creating the space for legitimate moral disagreement. The same situation may still happen today as patients from different cultural and religious backgrounds may entertain very different attitudes with respect to truth telling (Surbone 2006). In these situations, fulfilling the formal conditions of logical validity and moral consistency would not aid physicians in assuming the deceived's perspective, as the clinician would only appraise how *she* would judge such an act if *she* were the patient.

In sum, the third level of publicity ensures that we are moral judgment is not biased by selfish or corporative interests, but it does not assure that such an evaluation would be still valid outside our system of beliefs and values. In order to control for this residual potential bias, we should carry on the process of public justification at another, more general, level.

(5.4.d) The fourth level of publicity: the perspective of the deceived

Even if the whole public of reasonable persons is taken into account, there is still one point of view that is missing from the picture: the one of those sharing the perspective of the deceived. Without taking into account the perspective of the deceived the final judgment might be

skewed on the perspective of the deceiver, as it would be a trial in which a court of law emits a verdict after having heard only the perpetrator's reasons but not those of the victims. Including the perspective of the deceived requires another step in the process of their articulating clinicians' reasons. At this last level, therefore, the TOP ought to include also the following question: Were this patient aware of her circumstances, would she agree that deception is the best course of action to pursue?

Depending on the circumstances there are several ways in which clinicians might take into account the perspective of deceived. In general, however, there are three broad categories of cases. First, there are the cases in which clinicians can ask directly to the patients whether they would consent to the use of deception. (We shall examine these cases below). For example, in the context of medical research, participants in deceptive clinical trials may be asked to sign in advance an informed consent module in which it is made explicit that the information received during the trial may be incomplete or misleading in order to protect the scientific validity of the study. Importantly, in this way it is possible to include not just the perspective "of patients" in general, but to respect the perspective of "this" patient, with her individual needs, values, beliefs, and relationships—at least in principle.

In many cases, however, it would be self-defeating to inquire into patient's preferences about the use of deception (Korsgaard 1996).⁵⁸ Often deception has to be performed in secrecy to be successful, without arising any suspiciousness on the part of those who will be deceived. In all these cases, in order to answer to the latter version of the TOP, clinicians must rely on indirect sources of information about the patient's likely attitudes and preferences. For example, doctors can rely on what patients have previously made explicit ("I

⁵⁸ Korsgaard (1996, 155-156) has argued that if someone consents to be deceived, then this person would stop believe anything. In Korsgaard's words, "Sometimes it is objected that someone could assent to being lied to in advance of the actual occasion of the lie, and that in such a case the deception might still succeed. I can certainly agree to remain uninformed about something, but this is not the same as agreeing to be deceived. For example, I could say to my doctor: "Don't tell me if I am fatally ill, even if I ask." But if I then do ask the doctor whether I am fatally ill, I cannot be certain whether she will answer me truthfully. Perhaps what's being envisioned is that I simply agree to be lied to, but not about anything in particular. Will I then trust the person with whom I have made this odd agreement?". I think this view is too narrow; see (5.7).

do not want to know if the result is bad”), their personal acquaintance with them, and on what relatives and caregivers may know about their preferences. In any case, looking for individual preferences may help clinicians to anticipate how patients would react if the deception gets uncovered and thus to better evaluate the consequences of the deceptive acts.

The last scenario is the most extreme one, and occurs when it is impossible to ascertain patient’s perspective both directly and indirectly. For example, this is the case in which an unknown patient shows up alone in an emergency clinical setting. None of the medical professionals knows this patient, and there are no hints that may lead to reconstruct her social or cultural background. In these cases, the clinician may have insufficient information to characterize patient’s individual point of view. Whenever this happens, clinicians ought to substitute the perspective of this patient with the one of another reasonable person who might be imagined in the same situation.

(5.5) Merits and limits of the test of publicity: from hypothetical to actual publicity

The test of publicity allows clinicians to improve their decision-making processes as they evaluate the moral permissibility of deceptive acts. Specifically, by taking the TOP physicians may: (a) improve the identification of all the morally relevant reasons in favour or against an act of deception; (b) improve their argumentation through the identification of fallacious arguments and the clarification of key-terms (e.g., “individual autonomy” or “deception”); (c) control for those structural biases that are introduced by the discrepancy of the perspective as the sets of the reasons supporting or opposing a proposed deceptive act are weighted one against the other. If what I have argued so far is correct, then implementing the TOP in clinical settings represents a significant improvement over the way in which moral dilemmas about truth telling and deception are currently approached in medical ethics.

However, even if we agree that a systematic implementation of the TOP would result in better moral decisions, this does not mean that the TOP provides a perfect solution for every case—or that it is not in itself problematic. The TOP has merits as well as limits. As Bok noted, “The test of publicity is not always needed; where needed it cannot always be implemented; if implemented it does not always bring forth solutions to moral quandaries. Given these limitations it can nevertheless reduce the discrepancy of perspectives, shed light on moral reasoning, and facilitate moral choice” (1978, 103). The TOP is “not always needed” because some deceptive acts would not pass the prior test of veracity: there are cases in which a deceptive act is ruled out well before reaching the TOP; it “cannot be always implemented” because sometimes there is not enough time; and, sometimes it cannot “bring forth solutions to moral quandaries” because the dilemma at hand has simply no “right” solution: though one set of reasons must eventually prevail, there are cases in which the force of the respective sides might be almost equal and in which, even after the balancing, it is not clear what our actual duty should be.

More importantly, Bok’s perspective does not fully address another objection: namely, that the whole process from the TOV to the performance of the deceptive act can remain secret. Indeed, sometimes to meet the requirements of the TOP clinicians may actually discuss the moral dilemma at hand with their colleagues, peers, the patient’s caregivers, and sometimes even with the patient herself. However, clinicians can do so in indirect ways—e.g., by describing the case in hypothetical terms (“What would you do if...”). Thus, it is possible to apply the TOP and to keep the deception completely secret. The possibility of complete secrecy leaves the present account vulnerable to the critiques motivating categorical trust-based positions, namely: that the process whereby clinicians identify possible exceptions to the duty of veracity is arbitrary; and that the virtual unaccountability of clinicians may lead us to suspect of their overall moral integrity (see 4.4). Let us briefly discuss how these two critiques can be addressed to the present account, even when the TOP is implemented.

Implementing both the TOV and the TOP provides clinicians with a method for deciding when and how an exception to the duty of veracity is morally permissible. By leading clinicians to consider other perspectives other than theirs, decision-making processes implementing the TOP are arguably less biased than those without it. In this sense, this account convincingly answers to the critique of arbitrariness: *contra* Jackson (2011) and others, it is not true that there cannot be non-arbitrary ways of deciding which exceptions to the duty of veracity are ethical or not.

However, one might still object that even within the present account the risk of arbitrariness persists, although in a different form. It persists because it is always the clinician who is proposing the deception the one who judges whether she has successfully passed the TOV and the TOP. Thus, while applying the TOP may be of help in refining one's own argumentations, it does not completely solve the problem of arbitrariness, which is instead moved from the level of the judgment over the competing reasons pros and cons the deceptive act, to the level of the judgment over the success of the TOP itself. The TOP may ideally provide a non-arbitrary method for identifying permissible exceptions, but the judgment over whether the method has been correctly and impartially applied remains an issue that pertains to the "arbitrary judgment" of the single clinician.

The second critique, then, concerns the preservation of trust. Usually we trust that clinicians will abide to certain minimal standards of morality and competency. Without such fundamental trust therapeutic relationships would become impossible. However, this trust may be jeopardized by the legitimate suspiciousness that clinicians make unjustifiable exceptions to the rule of veracity either because they are too paternalistic or because they are motivated by purely selfish reasons. This suspiciousness is further motivated by the fact that clinicians can operate in complete secrecy and are thus unaccountable. Since they must not reveal *how*, *when* and *why* they have decided to "opt-out" from the duty of veracity, then one

might suspect of the truthfulness of all their communications—especially if one has already assumed the perspective of the deceived and being subjected to an act of deception.

Implementing the TOP would not make the present account immune from this critique. In fact, applying the TOP may raise clinicians' self-awareness about their responsibilities and lead them to better appraise the consequences of their actions, but it does not make them anymore accountable to the public eye than other methodologies: those who eventually decide to resort to dishonesty could still do so in complete secrecy. Thus, even by implementing the TOP, an exceptionalist account would still be liable to the critique that by allowing exceptions to the duty of veracity one might irremediably jeopardize the trust of patients, in particular of those that have already shared the duped's perspective.

These two critiques remain unmet because the TOP implements only a form of “hypothetical” and not of actual “publicity”.⁵⁹ Clinicians implementing the TOP have just to imagine how they would defend their acts in public, but they are actually never compelled to do so in practice. The TOP is only a mental experiment useful for better articulating one's own reasons in a less biased way; but it does not require clinicians to *publicly disclose* whenever they have resorted to deception. By contrast, if clinician would be required to implement some form of actual publicity the two above critiques would be easily avoided. As for arbitrariness, if clinicians were required to publicly disclose when and why they resort to deception, then they would also have a strong incentive to conduct the TOP impartially. Passing the TOP would still remain an issue of private judgment, but, at least, those taking it would be motivated to do their best to apply the test fairly. As for the preservation of trust, instead, implementing some form of actual disclosure would solve the problem of suspiciousness by

⁵⁹ This distinction is frequently drawn in political philosophy to distinguish two requirements for the acceptability of State laws—and especially of coercive ones. According to supporters of the idea of hypothetical publicity, a law is good only if those who will be subject to it can potentially agree upon it. This principle is usually attributed to Kant as he famously said that, “All actions relating to the right of other human beings are wrong if their maxim is incompatible with publicity” (Kant 1795). According to the defenders of actual publicity, instead, a law is legitimate only if those who will be subjected to it have actually agreed upon it. For a comprehensive overview of this debate see Grosseris (2005).

making it possible to know how, when and why an exception to the duty of veracity has been made, thus rendering those physicians who have resorted to deception publicly accountable.

The problem with actual publicity is that it seems to be too demanding. Clearly, it is impossible to organize every time an *ad hoc* audit commission, a citizen jury or a court of law as to literally translate the TOP in actuality. How should clinicians publicly disclose whenever they make exceptions to the duty of veracity? To answer this question, in the next section I will introduce the concept of “technique of actual publicity”. As I will explain, in general there is no need of resorting to complicated institutional and decisional devices because medical professionals are already using several techniques that satisfy the requirements of actual publicity. Therefore, I will argue, in order to meet the above objections, we have simply to extend the use of these techniques of actual publicity to all those cases in which a deceptive act is eventually performed in clinical settings.

(5.6) Solving the problem of secrecy: introducing the techniques of publicity

In medical contexts there are cases in which lying, deceit and concealment are already used in systematic and institutionalised ways. Consider the case, mentioned above, of a group of researchers in social psychology who decide to use a deceptive trial design to study people’s cooperative attitudes. In this case, resorting to a deceptive disclosure at the beginning of the trial is the only plausible way in which the scientists can preserve the scientific validity of the study. Today deceptive studies of this kind are common in psychology, sociology and even in medicine—for example in the field of placebo studies (Wendler and Miller 2008). The most striking case in this respect, however, regards the use of strategic concealment in double-blind randomized controlled trials (RCTs). In this trial design neither the researchers nor the participants are informed of which treatment each participant is receiving: this information is temporarily concealed in order to preserve the trial internal validity.

How is this possible? How do researchers succeed in securing these exceptions to the duty of veracity in ways that are *prima facie* considered ethical by individuals, society, and institutions? In this section I suggest that an important part of the answer to this question lies in what I shall define as the “techniques of publicity”. The “techniques of publicity” are all those public means used by medical professionals to prevent, control for, and mitigate the moral implications of a deceptive act. Despite their heterogeneity, what the techniques of publicity have all in common is that they are ways of *publicly disclosing* that an exception to the duty of veracity will or have been made. In some cases these techniques allow bridging the gulf separating the perspective of the deceivers and the one of the deceived; other times, instead, they can only mitigate the consequences that an act of deception could have for the capacities of individuals to act autonomously, their interpersonal trust, and the *bona fide* of society toward medical professionals. We shall now proceed in the following way: in this section I shall further characterize the concept of the “techniques of publicity”; in the next one I shall then explain how the systematic adoption of these techniques would complement my account.

Let us begin by considering two cases from research contexts: “debriefing” and “informed consent”. Among the conditions for approving deceptive studies, IRBs and ethical committees require the implementation of techniques of “debriefing”: once the study is completed the researchers must inform the participants of its true scope, disclosing them the use of deception. If participants think that the use of deception was not appropriate they forbid the researchers from using their data. Techniques of “debriefing” are used to protect the trust of future study participants and to partially restore participants’ autonomous agency—although in a *post hoc* way.

Something similar happens with informed consent, which is perhaps the most important technique of publicity that clinicians, bioethicists, and policy-makers have elaborated and implemented in the last seventy years (Faden and Beauchamp 1986; O’Neill 2002;

Beauchamp and Childress 2009). Obtaining a valid consent is today a necessary pre-condition for conducting any clinical and scientific study with humans. This is true of both deceptive studies as well as of those trials that use strategic concealment but not deception. In the first case, the informed consent may explicitly require the participants' consent to the use of deceptive techniques; in the latter case, instead, it may require them to temporarily waive their right to be informed about the kind of treatment that they will receive during the study. In both cases, the informed consent module absolves a similar function to the practice of debriefing: it publicly discloses to the prospective study participants that the researchers may or have used deception or concealment for preserving the internal validity of the study.

Despite their formal differences, debriefing and informed consent share a common goal: to balance the preservation of trust and the respect for autonomy with the need of using deception or concealment. In both cases this objective is achieved by disclosing that the researchers will be or have been untruthful in their communications with the study participants. The crux of both techniques, thus, is that of *voluntarily waiving the secrecy* that usually accompanies deceptive acts, publicly declaring that an exception to the duty of veracity has been or will be made. By disclosing *when, how* and *why* a deceptive act might or have been performed, the researchers waive their virtual unaccountability, hence preventing the phenomenon of the discrepancy of the perspectives from arising (e.g. informed consent before the trial), or explicitly facing its consequences (e.g. data withdraw after debriefing).

While these ways of publicly disclosing the use of deception and strategic concealment are commonplace in today research settings, analogous techniques exist also in clinical contexts. This is the case, for example, of techniques of “delayed” information disclosure. In delayed information disclosure clinicians first deceive or conceal information to a patient—for example in the “unhopeful surgeon case”—and then disclose the truth at a later stage, once the patient has physically and mentally recovered. A similar case occurs when clinicians resort to deceptive means for diagnostic purposes. Sometimes deception and concealment are the best

means to find out whether the symptoms reported by a patient have or not a psychosomatic component, hence allowing the clinician to select the most appropriate therapeutic path. After the diagnostic test has been taken, the clinician may disclose to the patient that the intervention that has been previously administered was just an inert one, hence explaining that the temporary deception was needed for selecting the best treatments.

Similarly to the case of informed consent before deceptive trials, patients in clinical settings can waive their right to receive certain kind of information in clinical contexts (Beauchamp and Childress 2009, 131-132; see also 6.10). In this case, patients may explicitly state their preferences while discussing with their clinician possible strategies of information disclosure. This may happen in the context of taking diagnostic procedures for genetic diseases or life-threatening conditions. By agreeing in advance what attitude the physician will take in disclosing the results of the tests, patient and physician may publicly accommodate the use of selective or deceptive disclosures. Like in research contexts, in all these cases the goal of these techniques is again that of publicly disclosing *when*, *how* and *why* an exception to the duty of veracity has or will be made. Under this respect, the main difference between the two settings is only that within research contexts the implementation of these techniques of publicity is a structured practice, whereas in clinical contexts their use is situational and left to the sensibility and judgment of individual clinicians.

In difference to the current *practice*, I argue that the implementation of techniques of actual publicity ought to be made systematic in clinical settings: those who have or will resort to a deceptive act must also publicly disclose what they will do or have done. This means that, in addition to the TOV and the TOP, clinicians who resort to deception in clinical settings must always adopt *at least one* techniques of actual publicity. Before considering how this proposal could be translated in practice, let us further characterize it with respect to the theory that has been put forward in this chapter.

In the view that I have proposed implementing a form of hypothetical publicity through the TOP is a necessary but not a sufficient requirement for a deceptive act to be morally justified. In addition to judging that a deceptive act is morally permissible through the TOP, those who are proposing to resort to deception must also take responsibility for preventing or mitigating the consequences of their acts. The implementation of hypothetical publicity must therefore be complemented with the implementation of *at least one* technique of actual publicity. In defending this view I must leave company with both Bok and Sokol, who consider instead the TOP to be the last step that clinicians ought to take in evaluating deceptive acts. Henceforth I shall refer to the test through which clinicians ought to select the best technique of publicity as the “test of public disclosure” (or TPD).

Importantly, there are some important differences between the test of publicity and the test of public disclosure. The most important difference is that the TOP is a mental experiment that implements a form of *hypothetical* publicity, whereas the TPD is a way of implementing a technique of *actual* publicity. While the first can be taken in complete secrecy of one’s own private conscience, the latter requires instead something to be publicly done. Another capital difference between the two tests is that the former demands clinicians to image how they would *defend* their choices from the criticisms of others, while the latter requires only that clinicians *disclose* whenever they plan or have made an exception to the duty of veracity. Adopting a technique of publicity does not automatically requires clinicians to defend their choices in front of an actual public—although it may create the preconditions for demanding such a public defence in exceptionally controversial circumstances.

(5.7) The techniques of publicity and the test of public disclosure

The “techniques of publicity” are all those means of publicly restoring, amending and justifying an exception to the duty of veracity. Informed consent and debriefing in RCTs,

authorized deception scripts, are all “techniques of publicity”, that is, ways of healing or preventing the damages of secret deceptive acts by making them publicly accountable. Depending on the context, one technique of publicity may be required instead of another; however, what is crucial is that for any deceptive act *at least one* technique of publicity is used. In this section we shall consider more closely how clinicians can translate this proposal in practice.

Let us begin with a characterization of the possible kinds of techniques of publicity, starting with what I shall consider as the ideal case: the obtainment of a valid consent for an openly deceptive study. As noted above, by obtaining such informed consent the researchers warn in advance the participants that they might be deceived during the study. By expressing their consent, the participants waive their right to be truthfully informed during the trial. This is an ideal case because those who will be deceived are informed of the deception before it occurs. Accordingly, they can autonomously decide whether or not they want to be subjected to it for the sake of promoting scientific knowledge and their trust will not be compromised. By contrast, those who participate in deceptive trials with debriefing are in a less favourable position: they can still decide to withdraw the data, but they cannot decide whether they consent to be deceived or not, as the deception has already taken place. Acknowledging this difference, we shall henceforth distinguish between *prospective* and *retrospective* techniques of publicity.

The two techniques of informed consent and debriefing, however, share one important characteristic: they are both addressed to the ones that will be or have been deceived. By doing so, they are either preventing or making explicit the difference between the perspective of the deceiver and the one of the deceived. In the case of informed consent this discrepancy does not even arise: since the ones that will assume the duped’s perspective have autonomously chosen so, they cannot blame the deceivers for the consequences of the

deceptive act.⁶⁰ In the case of debriefing, instead, the clash of the perspectives is made explicit by allowing the participants to veto what has been obtained by exploiting their trust. Henceforth, I will distinguish between *direct* and *indirect* techniques of publicity: direct techniques of publicity are those that are directly addressed to the deceived; indirect techniques of publicity are instead those that publicly disclose the deceptive act at others level of publicity.

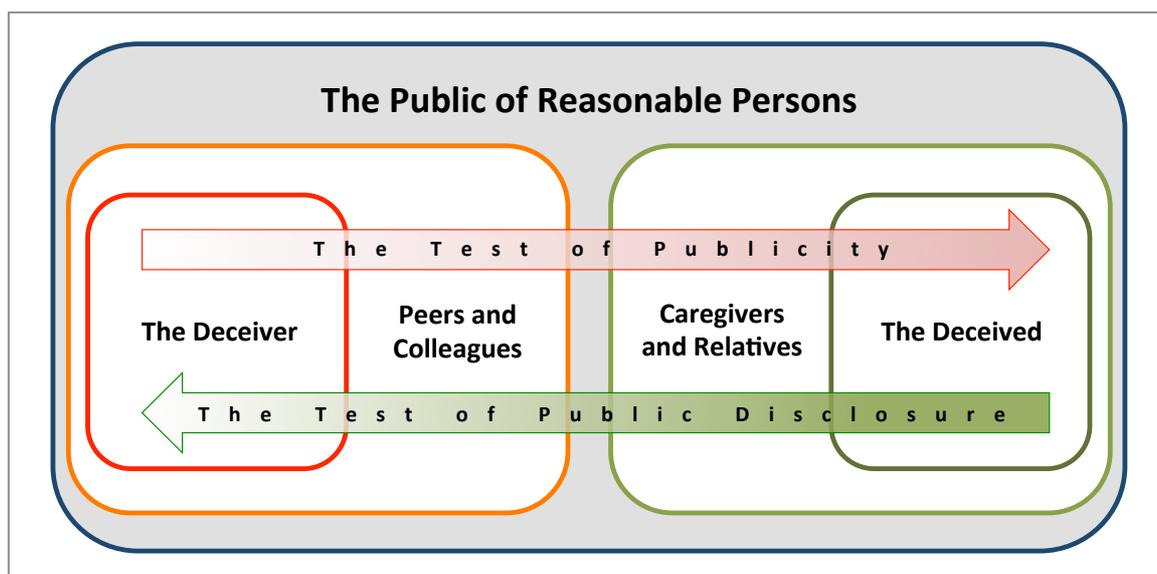
There are many situations in which the deception cannot be directly disclosed. One of these cases is the one of the old man who is demanding to his clinician if he has cancer (see 1.4.d). As I have argued, in this case it is ethical to lie to the inquiring patient out of compassion: the cancer can be easily removed surgically in day-hospital, and there seem to be no other plausible course of action for the clinician to be truthful while at the same time preventing a likely long-term, unnecessary, emotional shock with potentially severe consequences. Delaying the disclosure do not appear either as a viable alternative: revealing the use of deception may still lead the patient to entertain the false belief that his cancer “will always be there spreading”, and it might also negatively impact the quality of the doctor-patient relationship. Let us assume, for the sake of the argument, that in this case the proposal of using deception has already passed both the TOV and the TOP: how could the physician publicly disclose the deception if he cannot directly inform the patients neither prospectively nor retrospectively?

In this case, I propose that clinicians should nonetheless adopt an *indirect* technique of publicity. As we have seen while introducing the TOP, there are different levels of publicity that are arranged on the base of their relative distance with respect to the perspective of the deceiver. Hence, there is the first level of publicity that corresponds to the clinician’s private

⁶⁰ In discussing the various levels of publicity, Bok hints at the need of implementing forms of prospective and actual publicity: “If possible, such an open discussion should take place before the initiation of the deceptive scheme, giving those to be deceived an opportunity to be heard. To do so, is the only sure way of having the perspective of the deceived represented” (Bok 1978, 98).

consciousness. This is, of course, a *sui generis* kind of publicity, for it is a level to which nobody else has usually direct access. Then, the second level of publicity is the one of peers, that is, of all other persons sharing our perspective. Next, there is the level of those sharing the perspective of the deceived. On a different plane, then, there is the level of the public of all reasonable persons to which both the deceiver and the deceived belong as they engage in the play of exchanging reasons.

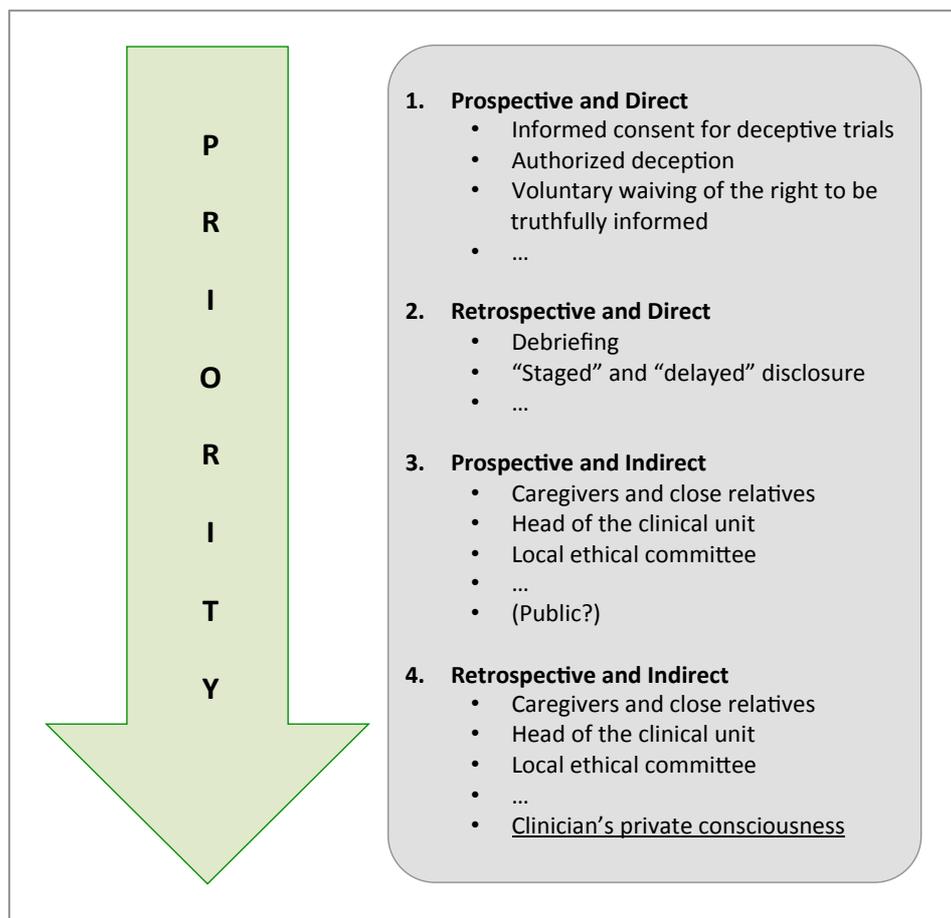
When there are no plausible direct techniques of publicity, which indirect ones ought the clinician to prioritize? I suggest that, in these cases, clinicians should follow an inverse order of priority with respect to the one adopted while taking the test of publicity, as depicted in the following diagram:



Therefore, if the patient in question cannot be directly informed, clinicians should disclose the deception to others who share the perspective of this individual patient such as caregivers and close relatives. If there are no caregivers or close relatives, then the clinician should find other indirect ways of publicly disclosing the act of deception, at least at the level of those who share her/his perspective. Here there might be different options, depending on the context. Clinicians may decide to write and submit a short case-report to the local ethical

committee, to disclose the deception to other clinicians, or even to submit a short article to ethical journals. In any case, the principle guiding the choice should be that the less private the disclosure is, the better it would serve its purpose. Since institutional bodies and person with a leadership position have a public stance, they should be generally prioritized over individual peers. Hence, it is better to disclose the decision of resorting to deception to the head of the clinical unit rather than to a fellow colleague. In all these cases, it applies also the previous distinction between prospective and retrospective techniques of publicity: if possible it is better to inform the head of the clinical unit before resorting to deception rather than afterwards.

With the *prospective/retrospective* and *direct/indirect* general distinctions in place, we are now in a good position to elaborate a general ranking of which technique of publicity ought to be prioritized in each case. The most favourable scenario occurs when a clinician can use a *prospective* and *direct* disclosure. By contrast, the worse scenario is when there are no other options than *indirect* and *retrospective* techniques of publicity: this case coincides with the clinician keeping the deception fully secret. In between these two extremes, there are many intermediate levels in which, other things being equal, clinicians should always prioritize those techniques that are prospective over those that are retrospective as well as those that are closer to the perspective of the deceived over those that are closer to their own private consciousness. The following schema captures these ideas:



The test of disclosure introduces an intermediary step between the TOP and the actual deception. Once the proposed deception has passed the TOP, clinicians should ask themselves whether they could still implement some prospective techniques of publicity. If such an option is not available, then they should evaluate which technique of publicity could be implemented after the deceptive act has been performed, prioritizing those that are direct and closer to the deceived’s perspective. Having identified which technique of publicity is the most appropriate one in that particular case, clinician can then proceed with the deception.

There are a few advantages associated with the proposal of implementing forms of actual publicity in clinical contexts. The first advantage is that of confuting the critique of secrecy and unaccountability that motivates categorical-trust based positions. This critique is that the virtual unaccountability of clinicians making an exception to the duty of veracity may raise a series of legitimate suspects about the way in which physicians decides in these cases.

Since clinicians are not required to take the TOP in any public and actual form (i.e. to defend their choice in any actual terms), then their evaluation on whether they have correctly applied the TOP could remain secret and thus be biased in the same way in which the standard evaluation of the reasons in other accounts is.

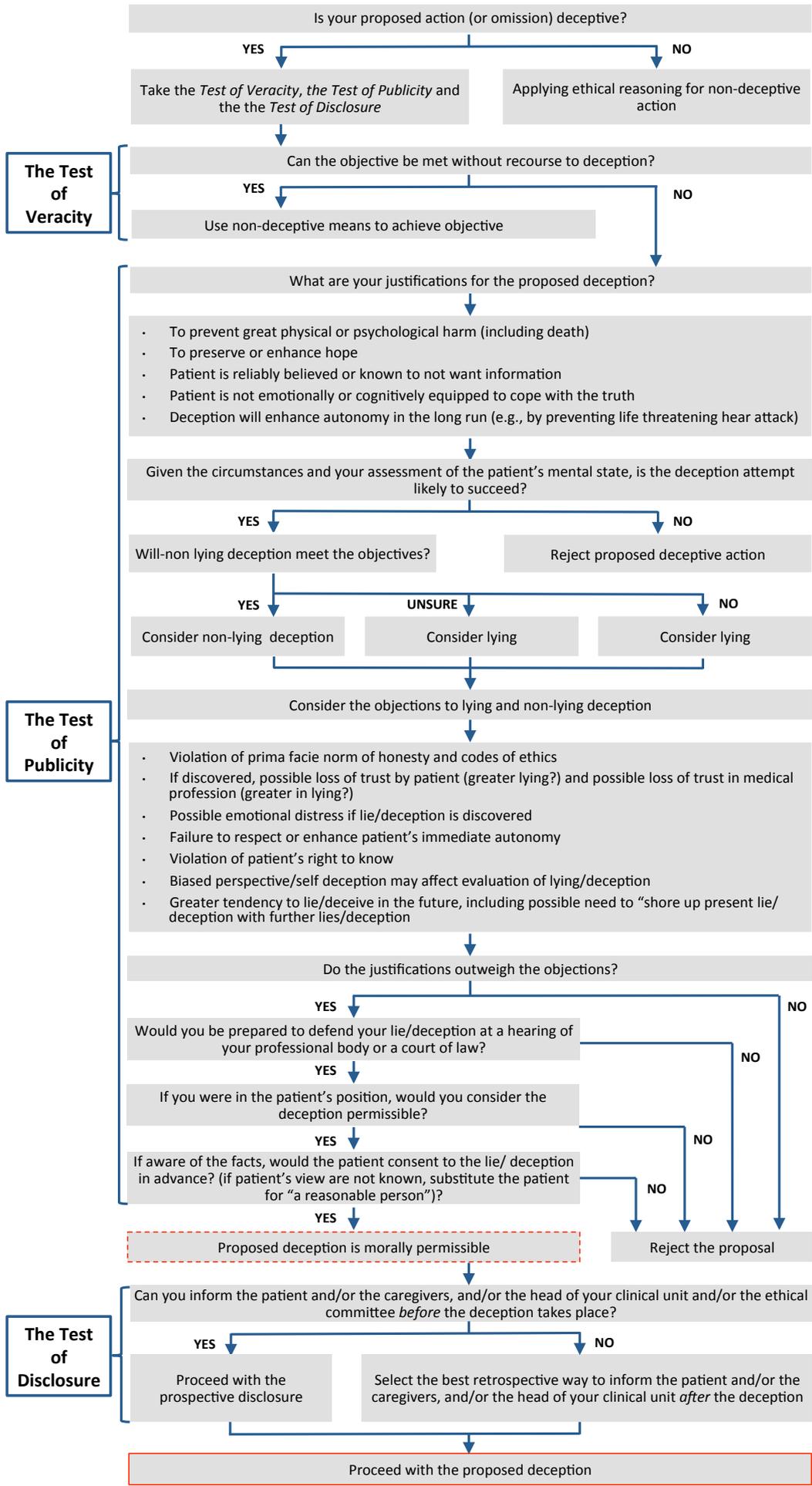
This critique loses much of its force once the TOP is complemented with the actual disclosure of the deceptive act, because the very fact of disclosing the exception provides a strong incentive to take the test seriously. The techniques of publicity have thus an “expressivist” function, which is to increase the awareness of clinicians taking the TOP about the potential consequences of their acts, hence incentivizing them to avoid arbitrariness and sloppiness. As for the critique about clinicians’ virtual unaccountability, it clearly falls with the introduction of techniques of publicity: the objective of publicly disclosing that an exception to the duty of veracity has been made, in fact, is precisely that of making clinicians accountable for it. Moreover, by endorsing transparency and accountability, clinicians and medical professionals would also reinforce the trustworthiness of their professional status.

There is, however, also a possible drawback. One of the problems in implementing my proposal is that prospective techniques of publicity are not always available. Sometimes clinicians have to decide quickly whether or not they ought to reply truthfully to patients’ direct questions. In these circumstances the clinician has little time to decide, and she cannot certainly be expected to ponder every aspects or to ask other more experienced colleagues for advices. Other times, instead, it would be unclear for the physician taking the test of public disclosure which practical options she has for disclosing the act of deception if the patient cannot be directly informed and there are no caregivers or close relatives. Since the community of peers is organized at many different levels, sometimes it is difficult to identify which disclosure would meet the requirement of actual publicity.

These practical limitations represent an important challenge for the implementation of the present account. However, these concerns are likely to be resolved as this proposal is progressively implemented in clinical settings. If clinicians start adopting adequate techniques of publicity in a systematic way, they are also likely to create over time some “best practices” that might subsequently help clinicians in similar positions to meet similar concerns. For example, after observing a few analogous cases in which physicians have reported the use of deceptive means with the same category of patients, the head of a clinical unit may decide to discuss with other peers whether it is the case to implement some better techniques of publicity to cope with these cases. Opening a discussion about the need to address the consequences of deception may lead to the creation of new options, from the introduction of prospective information disclosures to the teaching of focalised material in medical schools. In other terms, by opening a conversation about deception and publicity, the adoption of the present view may aid in enlarging the set of options at the clinicians and patients’ disposal.

(5.8) A decisional flowchart for guiding clinical decision-making

A possible objection to my account is that it is too demanding: implementing the tests of veracity, publicity and disclosure require time and cognitive resources; yet clinicians must often take rapid decisions. To address the same issue, Sokol (2007) has proposed a decisional flowchart to aid physicians in deciding whether a deceptive act is morally permissible. Sokol’s proposal explicitly builds upon Bok’s analysis and is therefore compatible with the view that I have so far elaborated in this chapter. As such it shares all of its merits as well as some of its limitations: like Bok, also Sokol fails to acknowledge that without a requirement for actual publicity the whole procedure risks to be biased and eventually self-defeating. To resolve this and other minor issues, I have modified Sokol’s original flowchart to include also the level of the techniques of actual publicity into account. The resulting diagram provides a practical summary of the view that I have defended in this chapter:



The Test of Veracity

The Test of Publicity

The Test of Disclosure

(5.9) Four advantages of the proposed account

In this concluding section I shall further characterize the account that I have defended by underscoring its main advantages with respect to other competing alternatives in contemporary medical ethics.

First, this account avoids the many pitfalls of categorical positions while at the same time enforcing a strict prohibition on using deception in clinical settings. The view that I have defended is quite demanding in terms of requirements: passing the test of veracity, the test of publicity and the test of disclosure might require an active effort on the part of the physician proposing the deception. Arguably, only a few deceptive acts would be judged morally permissible if the tests are correctly applied. This is to be expected: the use of deception is very risky, especially in clinical settings, and therefore the rule of veracity must be strictly enforced, even if it remains a *prima facie* rule. In difference to all categorical positions, however, the view that I have defended provides also a flexible tool that allows coping with extreme scenarios, like for example the one of the “murderer at the door” or the other various scenarios that have been presented in the introduction. Thus, the present account is able to capture our moral intuitions about the bad consequences of resorting to deceptive means without falling into the paradoxical or unwanted consequences of other absolutist positions.

Second, the view that I have elaborated differs from other accounts in medical ethics as it is grounded on a wider analysis of the moral implications of deception for both trust and individual autonomy. This broader focus has brought to recognize the mutual interdependence of the two main rationales that can be invoked to *prima facie* object to the use of deception in clinical settings. While most other accounts are motivated either by the will to preserve trust or by the will of respecting and promoting patient’s autonomy, my account assign to both rationales the role of necessary and possibly independent conditions for rejecting deception in clinical settings. Appraising the moral implications of untruthfulness

from this wider perspective is important because it allows identifying all the relevant reasons that ought to be considered when clinicians evaluate an act of deception.

Third, in difference to other accounts such as the one of Beauchamp and Childress, my proposal acknowledges the inherent biases that are entrenched in our moral judgments because of the discrepancy of the perspectives. Since we tend to appraise the same act of deception differently depending on whether we endorse the perspective of the deceived or the one of the deceivers, considering such an act only from one of these two perspectives is likely to lead to a skewed evaluation. With respect to a third, impartial, point of view deceivers will tend to excuse themselves more often than not, while the deceived will tend to condemn them more often than not. In each case, the evaluation of the reasons pro or cons a given act of deception is likely to be biased in one sense or the other. This phenomenon is even more important in clinical settings where doctors and patients are within an asymmetrical relationship of power and knowledge and doctors can often operate in complete secrecy. To solve this problem I have argued for the systematic implementation of a refined version of Bok's "test of publicity" as a mandatory requirement for clinicians considering the use of deception. Adopting the TOP leads clinicians to refine their argumentations by weeding out possible fallacious arguments and facilitates the identification of all the relevant reasons at stake, thus leading to recognise those acts of deception that are motivated only by selfish rather than by altruistic reasons.

Fourth, in difference to Bok's proposal, my account avoids the objection of complete secrecy. Moral decisions that are taken in complete secrecy can be biased (either because of the discrepancy of the perspective or because we fail to identify and correctly weight all the relevant reasons). Furthermore, by conferring a status of virtual unaccountability, institutionalized secrecy may cast a legitimate doubt on the moral commitment of physicians to adhere to the fiduciary pact binding them with patients: since we do not know how, when and why a clinician makes an exception to the duty of veracity we can never be sure that

she/he is not making unjustifiable exceptions. To cope with this problem I have proposed to complement the previous account with a further step in which clinicians who resort or have resorted to deception select at least one way of publicly disclosing it. By introducing and characterizing the concept of “techniques of publicity” I have thus argued that Bok’s requirement of hypothetical publicity is not sufficient to adequately fulfil its role unless it is complemented with the adoption of some form of actual publicity. Adopting the techniques of publicity has several advantages as they can: correct the biases entrenched in taking secret moral decisions; reinforce the trust between physicians and society; and foster the conversation about how clinician can best cope with deception in clinical settings.

(5.10) Four possible objections and four replies

In this last section I will consider four possible objections to the account that I have elaborated. In particular, answering these four questions allows for clarifying both the meaning of the theoretical approach that I have so far proposed and how clinicians and other health professionals may use the diagram presented in (5.8).

Objection (a). According to the diagram you presented, there exists a strict order in which the reasons for justifying a deceptive act ought to be articulated. As the diagram depicts, we should begin with the TOV, proceeds to the TOP and then conclude with the TOD. However, sometimes it is impossible or impractical to follow this order: for example one clinician may first determine what kind of disclosure would be ideal in one case, and then proceeds to ponder the reasons supporting or opposing the deceptive act only retrospectively; hence, how should one understand the diagram in light of this possibility?

Reply (a). The diagram is not meant to depict a rigidly unidirectional process. Rather, it provides only a rough blueprint for articulating our reasons as we evaluate the moral

justifiability of an act of clinical deception. In other words, the diagram provides what I argued is the best sequence of passages to be followed in ideal circumstances, that is to say, in absence of other relevant practical considerations. Other things being equal, following the sequence proposed in the diagram is the optimal thing to do. However, in actual circumstances, it is to be expected that the process of moral justification that occurs in practice may not be entirely identical to the one proposed in the diagram, as it is more likely to follow instead a back-and-forth approach. Nevertheless, my view is that, independently from the order that is actually followed, the process of moral justification for an act of clinical deception cannot be considered complete until all three steps have been implemented.

Objection (b). The perspective that you are proposing is very demanding: to go through all the diagram one may need a lot time and cognitive resources, as each step implies a decision to be taken, and such decisions can sometimes be very complex. This demandingness makes this approach useless in contexts in which clinicians have to take rapid decisions. In other words, this approach may be useful to take a more pondered decision while evaluating the patient's future therapeutic plan, but not for taking rapid decisions in ER contexts.

Reply (a). Indeed, demandingness is one of the chief characteristics of the account that I have proposed. As I have previously specified (see *infra* 5.7-9), this demandingness reflects the fact that clinicians' duty of veracity ought to be considered as being rather stringent. At the same time, however, this makes also the present account unsuited to take decisions in settings in which rapid decisions are needed. While I acknowledge that this may represent a limit to the practical usefulness of the view that I have defended, I do not think that it provides any ground for considering its application less desirable for two interrelated reasons. First, this objection does not apply only to my account, but rather to any other non-categorical view. By definition non-categorical views set a default attitude, but require us to take a decision whenever we detect a potential moral dilemma. Resolving these moral dilemmas inevitably implies that we need to evaluate the alternative at stake, and then decide what ought to be

done all things considered. But again, this process requires time and cannot often be carried out if what we need is not a reasoned conclusion, but a rapid decision. This is a practical limit of any non-categorical view of applied ethics, rather than a specific drawback of my account.

However, this does not mean that my or other non-categorical accounts cannot be relevant in emergency-like situations. As explained in (5.7), by implementing the TOD, my view may have an explicit “expressivist function”: since clinicians have anyway the duty to disclose that an exception to the duty of veracity has been made, they can always use the diagram as a way of articulating their reasons in a retrospective way. This may in any case result in a better defence or justification of what has been done, also in emergency-like situations. Moreover, it is to be expected that in the long run implementing the TOD may bring about guidelines and shared “best practices” that can be also directly useful to deal with emergency-like situations. A clinician may thus be unable to use my view in one single case, but if enough similar cases occur, then through the TOD it is likely that such clinician will in the long run refine and adopt better ways of dealing with similar circumstances.

Objection (c). As you explained in the first chapter, attitudes toward clinical truth telling have been shifting in the last decades and they are still widely different across cultural contexts. However, it seems that the diagram provides a one-size fit-all approach that do not take into adequate considerations these possible differences.

Reply (c). On the contrary: the view that I have proposed is flexible enough as to take into consideration not only cultural but also personal differences regarding clinical truth-telling. In fact, the diagram is fairly open-ended, and it leaves some room to take into consideration possible cultural, moral, and individual preferences. This is explicitly the aim of the TOP, after all, through which clinicians ask themselves whether they would be ready to defend their deceptive act in public, that is to say, in front of their colleagues, the patient and other reasonable persons. Clearly, this very approach would lead to different answers in different

times and cultural context. For example, in front of the same situation, a doctor from the beginning of the 20th century may reach a different conclusion about what ought to be done as compared to one clinician who has been trained at the beginning of the 21th century. In other words, the diagram indicates *how* we should articulate in any one case our reasons, not *what* ought to be done irrespectively of the specific socio-cultural context in which the decision takes place.

Objection (d). Throughout the previous chapters you have defended a view for which the justifiable use of clinical deception ought to be considered as an “exception” to clinicians’ duty of veracity. However, is this view is extended to every doctor-patient communication, for example in oncological contexts, it seems that these “exceptions” are instead fairly common.

Reply (d). I concede that in some specific contexts clinicians may somehow depart from a strict adherence to their duty of veracity in ways that are not very problematic, currently accepted, and not so uncommon. With reference to oncological clinical settings, for example, it might be the case that clinicians frequently dealing with terminally ill patients may resort with a certain frequency to techniques of delayed or partial information disclosure in way that are incompatible with a rigorous adherence to the positive *prima facie* duty of truthfulness but that would nonetheless pass all the tests described in the diagram. In these cases it appears that while one can still argue that clinicians have a *prima facie* duty of veracity, the cases in which such duty can be legitimately overridden in favour of other *prima facie* duties are too common to be defined “exceptions”. Nevertheless, there are two reasons for which, even in the light of this consideration, we may want to consider clinicians’ duty of veracity not just as a *prima facie* duty, but as a rather strict one, that is to say, as a *prima facie* duty that can be overridden only in exceptional circumstances. First there are reasons concerning the importance of truth telling (see chapter 3). Second, not every clinician operates in contexts in which the circumstances forces moral dilemma about truth telling on a daily basis. Since the theory that I am proposing aims at being applicable to all clinical settings, it is then arguably

still reasonable that in the vast majority of the cases clinical deception or selective disclosure is unethical and should therefore be avoided, hence accounting for an “exception” to clinicians’ duty of veracity.

(5) Summary

In this chapter I have defended the view that benevolent deception may be morally permissible in whether three conditions obtains: that other plausible courses of non-deceptive action have been ruled out; that those committing the deceptive act would be ready to defend their conduct in front of a public jury composed not only by their peers, but also by those who will be deceived and in principle by every *reasonable person*; and, finally, that the deceptive act is eventually disclosed. In elaborating this view I have first shown the similarities between Bok’s principle of veracity and Ross’s conception of *prima facie* duties, emphasizing how they similarly interpret the structural imbalance between truthfulness and falsehood in the terms of a difference at the level of moral reason-giving.

Then, I have presented a refined version of Bok’s test of publicity as a practical methodology for clinicians for better articulating their reasons in favour and against a proposed act of deception. By implementing the TOP, clinicians’ decision-making is less likely to be biased by self-interests and self-deception. However, I have also argued that Bok’s proposal is not entirely satisfactory because in many cases it would not be able to control for the bias which are entrenched in any privately conducted moral evaluation in which we have some interest involved. This limitation stems from the under theorization of the distinction between hypothetical and actual publicity, which exposes this account to the critique targeting the secrecy usually conceded to clinicians in clinical settings.

To solve this problem I have proposed to adopt the concept of the “techniques of publicity” and consequently the test of public disclosure as a way of complementing the previous account. By adding the requirement that clinicians must in any case identify and adopt the best technique of publicity it is possible to reply to the objections motivating categorical trust-based positions as well as to achieve other objectives, such as the ones of increasing interpersonal and social trust and of incentivizing clinicians to avoid sloppiness and selfishness while applying the test of veracity and the test of publicity. The resulting view is that benevolent deception is morally permissible only if the justification of such an act would pass the test of veracity, the test of publicity, and the test of public disclosure. To underscore the pragmatic import of this view, I have then proposed a modified version of Sokol’s decisional flowchart to aid physicians in taking better decisions in real-case scenarios.

Part II

Veracity, Deception and Placebo Effects⁶¹

Over the last forty years a converging series of empirical studies has revolutionized the way in which placebo effects have traditionally been conceptualized in medicine. These studies suggest not only that placebo effects may be ubiquitous across research and clinical settings, but also that they may modulate patient's health-relevant outcomes in a plethora of conditions such as pain, depression, irritable bowel syndrome, Parkinson's disease, and recurring migraine. These empirical findings have revamped the debate over the moral permissibility of administering placebos in clinical contexts.

The main ethical issue pertaining to the clinical use placebos concerns the use of “paternalistic”, “therapeutic”, or “benevolent” deception: Is it ever permissible to lie, deceive, or conceal information to patients for the sake of promoting or inhibiting placebo responses? In order to answer this general question, in the second part of this dissertation I will apply and further extend the theoretical framework elaborated in part (I) with the aim of determining how clinicians' *prima facie* obligation of veracity ought to be specified in the light of new empirical discoveries about the underlying mechanisms of placebo (and nocebo) responses.

This second part is divided into two chapters. In chapter six I analyze the traditional debate over the moral permissibility of administering deceptive placebos. In difference to current practices, categorically restrictive policies, and the accounts advanced by other scholars, I will argue that the use of deceptive placebos is morally permissible in exceptional cases.

⁶¹ This second part is partially based on Annoni (2013); Annoni and Miller (2015a; 2015b).

In chapter seven, then, I discuss the moral implications of using verbal techniques of “therapeutic communication” to promote or inhibit placebo responses, and of administering physical placebos without deception (open-label placebos). In particular, I will defend the view that clinicians and oncologists may already implement within their routine clinical activities several adjuvant techniques of therapeutic communication as to provide patients with a superior quality of care in non-deceptive, low-risk and highly cost-effective ways.

6. The Ethics of Deceptive Placebos

The giving of a placebo –when, how, what–seem to be a function of the physician,
which, like certain function of the body, is not to be mentioned in polite society.

Pepper

He who cannot dissimulate cannot cure.

Hoffman

(6) Introduction

In this chapter I discuss the ethics of administering deceptive placebos in clinical contexts. What follows is divided in two parts. First, I will introduce the main coordinates of the current debate over the moral permissibility of using deceptive placebos in clinical contexts. Section (6.1) provides a synthetic reconstruction of the historical debate about the clinical role of placebos; section (6.2) introduces some preliminary definitions and conceptual distinctions; section (6.3) inquires into whether deceptive placebos have clinically relevant effects; section (6.4) explores whether placebos are clinically effective without deception; finally, (6.5) reviews available evidence about the use and attitudes towards the clinical use of placebos. In the second part of the chapter (6.6), I analyze a series of arguments that have been used to argue for or against the clinical use of deceptive placebos, finding them all wanting. Section (6.7) confutes the view that it is possible to administer placebos in ways that are non-transparent and yet not deceptive, hence avoiding the traditional moral quandaries of resorting to deception; then section (6.8) explores the claim that deceptive placebos are aligned with patients' preferences and thus do not compromise their autonomy and trust; section (6.9) criticizes Foddy's (2009) position that placebo are "always safe" and "often the best available treatment"; finally, section (6.10) analyzes the ethical underpinnings motivating the "placebo policy" endorsed by the American Medical Association (AMA), arguing that it provides a suboptimal starting point to think about the clinical use of deceptive placebos.

(6.1) The origins of the placebo debate

The genealogy of the term "placebo" leads back to the Hebrew Bible, when in the 4th century St. Jerome translated the word *ethalekb* with the Latin verb "placebo", i.e., "I shall please"

(Shapiro and Shapiro 1997, 28; Jacobs 2000).⁶² The first known use of the word “placebo” in medicine dates 1772, when the Scottish professor of medicine William Cullen stated in a lecture:

Mr. Gilchrist will bear me testimony that at first view I considered him as absolutely incurable, and as hastening very fast to his fate, and I took him in hopes of making some observant upon his case, and even of learning something by his death, I prescribed therefore in pure placebo, but I make it a rule even in employing placebos to give what would have a tendency to be of use to the patient (1772, 218f).

This quote exemplifies the double role that placebos have played in medicine up to mid of the 20th century: on the one hand, they served as tools of intentional ignorance in clinical experiments to gain scientific knowledge (Kaptchuk 1998a); on the other hand, they served as instruments of the healing arts to please the patient and ease the doctor’s work.⁶³ In the rest of this chapter we shall focus only on this latter aspect, that is, on the role that placebos played in clinical contexts as distinct from the one they played in research.

In medicine, the practice of administrating sham interventions has been fairly common until 1950.⁶⁴ In 1803 Thomas Jefferson noted that “one of the most successful physicians I have even known has assured me that he used more bread pills, drops of colored

⁶² The word “placebo” acquired a more secular meaning only in 14th century France, when it was customary for mourning families to dispense a meal after the Office of the Dead. To profit from the banquet, distant relatives and unrelated persons used to sneak in by simulating grief and desperation, joining the rest of the congregation by the time of singing the Psalm 116:9: “Placebo Domino in regione vivorum” (“I shall please the Lord in the land of the living”). Accordingly, these people were called “placebo singers”, or “placebo” (Shapiro 1968).⁶²

⁶³ Shortly after this lecture, Motherby’s *New Medical Dictionary* defined a “placebo” as “A common place method or medicine” (1785) and, a few years later, Fox’s *New Medical Dictionary* as “an epithet given to any medicine adopted more to please than to benefit the patient” (1803). A placebo was then something deprived of real healing powers but with the capacity of relieving patients. According to Shapiro and Shapiro (1997, 31), the first definition of placebo as “an inactive substance” in a dictionary dates 1894, while its first definition as something “inert” dates from 1942.

⁶⁴ Before the late 17th century the use of “bogus” treatments had been probably non-existent in Europe. The reasons lie in the ideas of “disease” and “cure” that were characteristic of that time. Instead of being an ontologically isolated entity a “disease” was more a unique personal condition. Consequently, “a treatment targeted the ‘person’ who manifested as a singular ‘gestalt’. An appropriate treatment—including regimes, behaviour, herbs, and/or words—always existed for a humoral disorder; there was never a need for a simulated treatment [...] For magico-religious healers, bogus treatment was even more unthinkable. The supernatural realm provided an endless source of potential healing possibilities [such as performative speech acts]. Religious healing was always a source of relief in this world or the next. Self-defined dummy treatments were simply unnecessary” (Miller et al. 2013, 1-2). Risse (1986), in his book *Hospital Life in Enlightenment Scotland*, writes that at the end of the 18th century physicians often used placebos whenever they were unsure about the diagnosis, wanted to buy some time and observe the natural course of the disease, or the case at hand was so desperate that relief was the only option left. Placebos were thought to lack any capacity to influence the causes of the patient’ actual diseases, and the ethics of their provision was grounded solely on considerations of paternalistic beneficence.

water, and powder of hickory ashes, than of all other medication put together” (Jefferson 1898). He famously defined this practice as “the pious fraud”. A century later Richard Cabot, a prominent Harvard physician, observed how he “was brought up, as I suppose every physician is, to use placebo, bread pills, water subcutaneously, and other devices” (1903). Another article entitled *Placebo* from 1885 confirms that, at the end of the 19th century, it was common routine to give an entire “polychromatic assortment of sugar pills” to unaware patients (Anon, 1885).

Still in 1945, one of the first scholarly papers on to this topic, concluded that a placebo was able to “smooth [the patient] path”; that “it cannot harm and may comfort”; and that it was especially useful for the “ignorant [...] disappointed and displeased [...] hopeless, [and] incurable case[s]” (Pepper 1945). Shortly after, a *Lancet* article entitled “The Humble Humbug” vividly characterized the role of the placebo in medicine as

[a] means of reinforcing a patient’s confidence in his recovery, when the diagnosis is undoubted and no more effective treatment is possible; that for some unintelligent or inadequate patients life is made easier by a bottle of medicine to comfort their ego; that to refuse a placebo to a dying incurable patient may be simply cruel; and that to decline to humour an elderly ‘chronic’ brought up on the bottle is hardly within the bounds of possibility (Anon 1954, 321).

From the time of the “pious fraud” to the one of the “humble humbug” placebos in general practice were thus conceived as inert remedies unable to influence the pathophysiology of diseases. Accordingly, their primary role was that of providing “mental relief” to uneducated, unintelligent or desperate patients. In the absence of ethical guidelines, placebos and therapies were therefore both delivered by following the classical Hippocratic rule “help, or at least do not harm”. Since placebos could “help” without harming, the benevolent deception required for their administration was frequently practiced, normally excused, and often considered one of the hallmarks of the doctor-patient relationship.

After World War II, two factors conspired in changing the ethical debate over the clinical use of placebos. The first one was the rise of respect for autonomy as a basic principle in medical ethics. After the 1947 Nuremberg trial it was established that people have a right to refuse medical procedures (Faden and Beauchamp 1986). In order to authorize or veto an intervention, however, patients need to be informed about it. Thus, as discussed in part (I), physicians came to have a duty to disclose to patients truthful information about their diagnosis, prognosis and the nature of prescribed treatments. With the emergence of honesty and transparency in communication as a key value for all health professionals, the “pious fraud” associated with the traditional use of placebos became increasingly considered as a relic of the bygone age of medical paternalism. The second decisive factor, then, was the series of scientific investigations that in the last forty years have progressively uncovered the neurocognitive mechanisms of placebo responses, demonstrating that the provision of a deceptive placebo may sometimes provide patients with something more than “mental relief”.

Before exploring the ethics of using deceptive placebos in clinical practice, however, it is necessary to consider four preliminary questions, namely: (a) What is a “placebo”? (b) Do placebos have clinical relevant effects? (c) Do placebos require deception to be clinically effective? (d) How often and why are placebos used in clinical settings? In the next four sections we shall synthetically explore each of these crucial aspects of the placebo debate.

(6.2) “Placebo” and “placebo effects”: preliminary definitions

The first difficulty in analyzing the ethics of placebos and placebo effects is that it is unclear what “placebo” and “placebo effects” are. In fact, there is unanimous consensus that the placebo construct is one of the most misleading concepts in contemporary medicine (Miller and Kaptchuk 2008; Miller and Brody 2011). It has been argued that “the placebo concept as

presently used cannot be defined in a logically consistent way and leads to contradictions” (Gøtzche 1994), and thus that “[w]e need to stop thinking in terms of placebo” (Nunn 2009).

For the purpose of the present analysis, however, I will define a “placebo” as any medical intervention believed to be inactive for the patient’s condition but administered by health professionals as if it was an active treatment (Miller and Colloca 2009; Annoni and Miller 2015).⁶⁵ Depending on the circumstances and on the biomedical theory assumed, a placebo can thus be a pill, an injection, an exercise regime, a diagnostic or even a surgical procedure (Grümbaum 1986; Benedetti 2011; Miller et al. 2013).

A distinction that is usually drawn is the one between “pure” and “impure” placebos. A placebo is said to be “pure” if it is believed to lack therapeutic properties in general for the condition being treated (e.g. lactose tablets, saline injection, cornstarch pills etc.). By contrast, a placebo is said to be “impure” if it is a treatment which is used as a placebo but which is also known to be effective for other conditions or under diverse modalities of administration. Common examples of “impure placebos” are antibiotics used to treat viral infections, over-the-counter analgesics, or vitamins for cold (Brody 1982; 1985; Miller and Brody 2011). Pure placebos are often described as “inert” or “inactive” but this is misleading: even lactose pills or saline injections contain “active” ingredients that have biochemical properties and may induce quantifiable changes (for example, a saline injection will raise the water level in the blood stream). The distinction between pure and impure placebos is therefore not always sharp.

⁶⁵ There is a fundamental ambiguity in defining a placebo as “a treatment that is believed to be ineffective for the condition being treated” insofar as the subject holding the belief is left unspecified. It is in fact possible that a physician *believes* a treatment to be effective even though there are no empirical studies demonstrating its efficacy according to the standards of evidence-based medicine (Howick 2011). Since it is possible for different physicians to hold different beliefs about the efficacy of diverse treatments, the definition of what is “a placebo” is inherently blurred. For a detailed analysis of how this problem may impact the way in which clinicians might protect patients’ trust, respect patients’ autonomy, and administer placebos in beneficial ways, see Barnhill (2012). Furthermore, the distinction between “active” and “inactive” treatments is murky; see Miller and Brody (2011).

The concept of “placebo effect” is possibly more confusing than the one of “placebo”. Currently, there is no agreement on how “placebo effects”, should be conceptualized. What is clear, however, is that traditional, dictionary-like definitions of “placebo effects” as “a positive effect following from the administration of an inert placebo” are inadequate. First, this kind of definitions perpetuates the conceptual paradox according to which something “inert” (i.e., the “placebo”) is said to cause an effect (i.e., the “placebo effect”). Second, as we shall see in the next section, while the administration of a treatment (placebo or not) may cause a “placebo effect”, other variables of the healing context may likewise induce a placebo effect without the administration of physical interventions (see 6.3).

In an effort to capture within a unique concept the multifaceted nature of “placebo effects”, over the years several scholars have proposed to re-conceptualize the concept of “placebo effect” in the terms of “context effects” (di Blasi et al. 2001; Miller and Kaptchuk 2008), “meaning response” (Moerman 2002), “symbolic aspects of the therapy” (Brody 1995), “interpersonal healing” (Miller et al. 2009), “positive care-effect” (Blease 2012), or as the “alief effect” (Haug 2011).⁶⁶ While none of these definitions has so far gained prominence, for the purposes of the following inquiry I shall stipulate that by “placebo effect” or “placebo responses” I mean any modification in a patient’s health-related outcomes that derive from contextual aspects of the clinical encounter rather than from the specific effect of therapies.

A third reason for why these dictionary definitions are inadequate is that empirical studies have now revealed the existence of an interesting flipside of the placebo-phenomenon: the “nocebo effect”. Nocebo effects are “adverse events produced by negative expectations and represent the negative side of placebo effects” (Colloca and Finniss 2012, 567). In parallel with the previous definition, by “nocebo effect” or “nocebo responses” I shall henceforth

⁶⁶ Haug (2011) elaborated an interesting proposal based on the idea of “alief” developed by Gendler (2008). According to this view, an “alief is associative, automatic, and arational. As a class, aliefs are states that we share with nonhuman animals; they are developmentally and conceptually antecedent to other cognitive attitudes that the creature may go on to develop. And they are typically also affect-laden and action-generating” (Gendler, 2008a, p. 641). According to Haug, this concept would be able to provide a unitary perspective on placebo effects that avoids the limitations of the classical perspectives.

mean any adverse modification in a patient's health-related outcomes that derive from contextual aspects of the clinical encounter rather than from the specific effect of therapies.

(6.3) Do placebos have clinically relevant effects?

In 1955 Henry Beecher conducted a proto-systematic review of 15 placebo-controlled trials, concluding that the average number of people that had experienced relief in the placebo group was 35.2 %; i.e., over one third of the total. Beecher's study aimed at demonstrating that people assigned to control groups in clinical trial might experience real improvements in their conditions despite having received no "active" or "real" medication, and therefore that it was impossible to assess the efficacy of a new medical interventions *unless* one compared it with an inert control (i.e., "the placebo"). Beecher's article, famously entitled "The Powerful Placebo", had an enormous impact, and represented a watershed for the way in which placebo and placebo effects came to be conceptualized within and outside biomedicine.

Although Beecher's study had many methodological limitations and was based on unproven theoretical assumptions (Kienle and Kiene 1997), in the last four decades a converging series of laboratory experiments, clinical trials, and neurocognitive studies has partially vindicated his conclusions about the existence of a powerful placebo effect. Empirical evidence on placebo effects comes from three main sources: (a) RCTs specifically aimed at studying placebo effects; (b) over forty years of controlled experiments; (c) recent studies with brain imaging techniques. Collectively these complementary strands of empirical research have shed considerable light on the psychological and neurophysiological mechanisms underlying placebo responses (Benedetti 2011).

However, while the reality of placebo responses is beyond dispute, the extent to which placebo effects can be harnessed to induce clinically relevant effects is still controversial. In a series of Cochrane systematic meta-reviews entitled “Placebo interventions for all clinical conditions”, Hróbjartsson and Gøtzsche (2001; 2004; 2010) analyzed over 330 trials and concluded that placebo interventions had no “significant clinical effect”. Placebos were found to have a marginal effect only on outcomes that were subjective (either patient or observer-reported) and continuous—most notably pain. These results led to question whether the placebo effect was “powerless” rather than “powerful”, and to what extent the results attributed to “placebo effects” were instead the product of subjective report biases.

Hróbjartsson and Gøtzsche meta-reviews prompted several responses within the field of placebo studies (Miller 2001; Kaptchuk 2001; Wampold et al. 2005; Meissner 2005; Howick et al. 2013). These replies underscored that these meta-reviews “examined placebo effects in medical experiments, where subjects are aware that they may or may not be receiving placebos. In the clinical contexts, placebo effects are likely to be stronger because patient are led to believe that they are receiving an active medication” (Kolber 2007, 89).

Aside from these methodological controversies, and in contrast with the results of these meta-reviews, most of the claims supporting the case for the clinical effectiveness of placebos are based on the results of high-quality laboratory studies and of experiments conducted in controlled conditions. In particular, in the last two decades, researchers have increasingly resorted to “open-hidden” experiments to separate placebo effects from other variables of the healing context and to assess their relative magnitude (Colloca et al 2008).

In this elegant trial design, the same medication is delivered to patients either in the full view of a clinician who openly describes the procedure and its anticipated effects (expected open administration) or covertly, for example through an intravenous infusion machine (unexpected hidden administration) (Levine et al. 1981; Gracely et al. 1983; Levine

and Gordon 1984; Benedetti 1995). The scope of open-hidden experiments is to assess whether it makes a difference to administer a drug while removing some variables from the healing context (e.g. patient-doctor communication; bedside presence of caregivers, etc.).

In one experiment of this kind, Amanzio et al. (2001) administered four commonly prescribed analgesics to patients in postoperative settings. In the open administration groups a doctor performed the procedure by telling the patient that the injection was a powerful painkiller and that the pain would soon subside. In the hidden administration groups, patients received instead the exact same dose of analgesics, this time delivered through an automatic infusion machine without anybody in the room and without emitting detectable signals. Patients were therefore unaware of when they were receiving the painkiller. The detected difference between the reliefs of pain in the two groups provided a measure of the placebo effect. The study found that the dose of analgesic needed to reduce the pain by half was significantly greater in the hidden administration groups for all four painkillers. Thus, the same dose of a proven analgesic had different effects depending on it being administered in an open or in a hidden manner. Similar results have been replicated with morphine (Benedetti et al. 2003a), and in conditions other than pain, including state anxiety (Benedetti et al. 2003a), and Parkinson's disease (Pollo et al 2002; Benedetti et al. 2003b).

In general, open-hidden experiments demonstrate that the effectiveness of therapies depends not only on *what* they contain but also on *how* they are delivered. The same dose of analgesics may have different effects depending also on other variables of the “healing context” such as the bedside presence of a nurse, or the way in which it is described. By “healing context” it is here meant the ensemble of rituals, tools, environmental features, and symbols associated with the delivery of therapies (Jonas 2011; di Blasi et al. 2001).

Among the components of the healing context some are of special importance and have been subjected to empirical studies. These studies suggest that variables such as the

doctor's attitude (Thomas 1987), her perceived confidence (Uhlenhuth 1966), the environment in which the therapy takes place (de Craen et al. 2000), and the ritual performed (Kaptchuk 2002), may all shape the final health outcome. For example, the formal characteristics of a therapy (i.e. its color, shape, timing) seem to have a measurable impact on its effectiveness. Branded placebos are more effective than generic ones (Branthwaite and Cooper 1981; Waber et al. 2008); sham surgery is more effective than sham injections, while sham injections are more effective than oral placebos (de Craen et al. 2000). Color and timing also matters, as blue and green placebos have been shown to be better in inducing sleep, while red ones are superior as stimulants (Hussain and Ahad 1970; Sallis and Buckalew 1984; de Craen et al. 1996). Also, placebos administered more frequently seem to have greater effects than placebo administered sparsely (De Craen et al. 1999; de Craen et al. 2000).

Placebo treatments may have effects that match or surpass those of standard medications. A study by Kaptchuk (2008) and colleagues investigated the hypothesis that it was possible to isolate two additive placebo components: (i) the one determined by the delivery of the therapy and (ii) the one determined by the interpersonal physician–patient relationship. The study was performed on 262 patients with irritable bowel syndrome (IBS). Participants were randomised into three groups. The first arm was the “no treatment” or waiting list and was meant to operate as the control for factors such as regression to the mean and spontaneous remission. In the second arm, patients received placebo acupuncture, but their relationship with the physicians was curtailed to a minimum—‘limited interaction’. Finally, in the third arm, patients received the same placebo acupuncture administered by warm, confident, and emphatic practitioners—‘augmented relationship’.

Results confirmed that for all four outcomes (global improvement scale, adequate relief of symptoms, symptom severity score, and quality of life) IBS patients in the limited interaction group reported more relief than those on the waiting list, but less than the ones 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. The magnitude of the response matched that of *alosetron* and *tegaserod*, the two most commonly prescribed drugs for this condition but which are known to have significant, even life-threatening, side effects. This study confirmed that non-specific effects can produce clinically significant outcomes and provided a first proof of principle that it is possible to isolate and combine diverse components of the healing context that induce placebo effects.

Another series of experiments in which placebo treatments seemed to have greater effectiveness than standard therapies is the so-called German acupuncture trials (GERAC) (Hacke et al. 2007). This double blind, placebo-controlled, multi-centred, parallel-group trial with 1,162 patients aimed at comparing traditional therapy (drugs and exercises) for chronic low-back pain against *verum* acupuncture and sham acupuncture (performed with retractable needles). Interestingly, this large evidence-based study found that between *verum* and sham acu punctures there was virtually no difference. More importantly, researchers found that acupuncture was almost twice as effective as the standard conventional therapy. Hence, in this case, a sham procedure proved to be more effective than the standard therapy.⁶⁷

Therefore, compelling evidence from controlled laboratory studies and clinical trials seems to support the claim that placebo effects may sometimes be significant—especially for conditions like pain, depression, and irritable bowel syndrome. However, these results ought to be interpreted with caution for at least two reasons. First, there is a relevant difference between controlled research environments and clinical contexts, and studies suggest that placebo effects are higher in the former setting than in the latter one (Benedetti 2011). Second, placebo effects are highly variable among individuals and healing contexts and thus highly unpredictable (Kaptchuk et al 2008; Hall et al. 2012). As Miller and Colloca (2009, 317) concluded in a comprehensive review of the literature, “[t]he upshot to date is that we lack

⁶⁷ For a methodological analysis and critique of these trials see Howick (2011).

systematic and definitive evidence of clinically significant benefit from placebo treatments. Accordingly, more clinically relevant research is needed before placebo treatments can be recommended as evidence-based therapy”.

In siding with this latter remark, I shall endorse a cautionary position regarding the possible clinical effectiveness of placebos. This position is based on two assumptions. First, the clinical effectiveness of placebos is likely to be limited to conditions that have strong symptomatic components like pain, IBS, and depression. Second, the clinical effect that placebo treatments might have for these conditions is typically highly variable, moderate and short-term. Thus, while on the one hand we might have good reasons to object to placebo treatments be recommended as evidence-based treatments in clinical settings, on the other hand, we might also have good reasons to support their use in specific individual cases.

(6.4) Do placebos require deception to be effective?

A crucial question concerning the effectiveness of placebo treatments is whether or not they require deception to induce significant placebo effects. Historically, the belief that placebos have to be administered deceptively or covertly to be effective has been widely shared. Clearly, since the main ethical issue concerning the clinical use of placebos regards the moral implications of resorting to “benevolent deception”, if placebos could instead be administered without deception the main issue hindering their use would disappear. But can non-deceptive placebos match the clinical utility of their deceptive counterpart?

Recent empirical studies on placebos “without deception” have questioned the widely shared assumption that placebos require deception to be effective (Krueger et al. 2006; Sandler and Bodfish 2008; Kaptchuk et al. 2010). In a pilot trial, patients with irritable bowel syndrome were randomized to receive either no treatment or a placebo pill that was honestly

described as containing no active medication (an “open-label placebo”, or OLP). Patients were read a script about placebo responses and informed about the rationale of the study. Perhaps surprisingly, patients who received OLPs reported statistically significant improvements with respect to the control group (Kaptchuk et al. 2010). Similar results have been replicated in other pilot studies for recurring migraine (Kam-Hansen et al. 2014) and depression (Kelley et al. 2012), suggesting that “taking a pill” may have beneficial effects even if that pill is not deceptively presented as an effective medication.

However, while these studies provide a first proof of principle that placebo effects can be induced not only by deceptive placebos, they do not demonstrate that covert and revealed placebos are equally effective. At present, more research is needed to solve this empirical question. Nevertheless, several authors have argued that, given our contemporary understanding of the placebo phenomenon, the burden of proof should be on those advocating the equal effectiveness of open-label placebos (Kolber 2007; Foddy 2009; Barnhill 2011). In fact, compelling evidence suggests that the magnitude of placebo effects may be influenced by the strength of patient’s expectations about future clinical benefits (Kirsch 1997; Colloca 2013). Since deceptive placebos affirmatively presented as effective medications are likely to elicit stronger expectations than placebos presented as “inert treatments”, it is reasonable to expect that deceptive placebos “might offer a medical benefit to some patients over and above the medical benefit offered by disclosed placebos” (Barnhill 2011).

Furthermore, independently of whether deceptive and revealed placebos are or not equally effective, covertly administered placebos can be used also with a diagnostic function, for example to discriminate real and pseudo-seizures in epileptic patients (see below, section 6.7). Clearly, utilizing a revealed placebo in these cases would be self-defeating, as the success of the diagnostic procedure may precisely depend on the patient being convinced that she is assuming a real medication. Thus, even if revealed and covert placebos would be equally

effective from a therapeutic point of view, this would not remove the question of whether deceptive placebos utilized with a diagnostic purpose would be ethical or not.

In sum, even if placebos without deception have clinically relevant effects, in absence of further evidence it is reasonable to hold that placebos administered with deception provides patients with an increased therapeutic benefit with respect to revealed placebos and that, in any case, only the use of deceptive placebos provides a plausible diagnostic tool in certain clinical scenarios. Thus, since there are cases in which the proposal to use a deceptive placebo would conceivably pass the “test of veracity”—for it would represent a plausible option in absence of alternative and truthful courses of action—one cannot entirely avoid the question of whether the clinical use of deceptive placebos is or not morally permissible.

(6.5) Prevalence and attitudes toward the use of placebos: a synthetic overview

In the last thirty years there has been an increasing number of empirical studies inquiring into the attitudes of clinicians toward the clinical use of placebos. These studies provide a useful starting point to answer three questions: (a) How often are placebos used in clinical settings? (b) Why do health professionals use placebos? (c) What are clinicians’ ethical attitudes toward the use of placebos? In this section we shall take a closer look at some of the major empirical studies that have been conducted over these issues.

In 2003 a national questionnaire survey of Danish physicians (772 practitioners) found that that 41% of private specialists, 54% of hospital doctors, and 86% of general practitioners admitted using placebos at least once—with 46% of the latter group reporting ten or more usages in the previous year (Hróbjartsson and Norup 2003).⁶⁸ Placebos were mostly used as

⁶⁸ In this study researchers “characterized a placebo treatment as an intervention not considered to have any “specific” effect on the condition treated, but with a possible “unspecific” effect (Hróbjartsson and Norup 2003). Interestingly, clinicians reported also different beliefs as to the efficacy of placebos: 51% believed that they could modify only subjective symptoms, 32% that they impact both subjective and objective symptoms; 9% did not believe in any effect; while the remaining 8% did not know. This means that, still in 2003, 68% of the

analgesics, with antibiotics for viral infection being the most used kind. The most cited reason to prescribe placebos was to “avoid conflicts with patients by complying with their treatment preferences”. Roughly half of the clinicians found deceptive placebos ethically acceptable, while 40% found their use unethical; still, among those who found placebo unethical 50% admitted of having prescribed them in the last year.

Similarly, a 2004 study in Israel found that the use of placebos for clinical purposes was widespread. Initially the researchers hypothesized that the use of placebos in clinical settings was more than zero but less than 10%. Results among the participants (31 hospital physicians, 31 head nurses, and 27 family practitioners) indicated otherwise: 60% admitted of using placebos (71% among the nurses), with 37% of using them as often as once in a month. Most respondents found that placebos were clinically valuable (94%). Only 4% honestly informed patients that they were receiving a placebo, while 11% told the half-truth that it was a “non-specific medicine”, 17% omitted saying something, and 68% resorted to benevolent deception. Interestingly, this study found also that besides using placebos after an “unjustified” request for medication, to calm the patient, and as analgesics, physicians used placebos also as diagnostic tools to distinguish “organic from psychogenic or simulated arthralgia, seizure disorder, and abdominal or other pain” (Nitzan and Lichtemberg 2004, 945).⁶⁹

A much larger study found that between 46% and 58% of U.S. internists and rheumatologists recommended placebo treatments. Also, this study found that nearly half of the participants (46%) admitted of recommending treatments solely for the purpose of enhancing patient’s expectations, while 62% considered the use of placebos to be either

interviewed physicians had mistaken or confused ideas about placebo effects. A systematic review similarly concluded that up to 50% of physicians and nurses [...] believed that placebo treatments are either always, often, or generally effective”, meaning that up to 50% thought that they were ineffective (Fässler et al. 2010, 12).

⁶⁹ This study did not investigate physicians’ ethical attitudes toward the use of placebos. However, it found that only 5% of physicians support a policy of total prohibition, while the majority see the use of placebos as conditionals on certain circumstances, such as prior experience (33%), notifying patients of receipt of a placebo (29%), or evidence from research that the placebo was effective (24%); (Nitzan and Lichtenberg 2004, 945).

obligatory or permissible in some circumstances. Interestingly, the study underscored that physicians prescribing placebos rarely used “pure” placebos (5%), as the vast majority used instead impure placebos such as over-the-counter analgesics, vitamins, antibiotics, and sedatives. The authors explained this result by underscoring the difficulty of writing a prescription for a sugar pill; the lack of marketed pills for such a use, and the reservations that one may have in knowing that a prescription is ineffective (Tilburg et al. 2004, 295).

The first systematic review (Fässler et al. 2010) analyzed 22 studies in 23 articles published between 1973 and 2009 and found that the proportion of health professionals reported of using placebos at least once a year varied between: 17% and 80% for pure placebos; between 54% and 57% for impure placebos and between 41% and 99% if both pure and impure placebos were addressed.⁷⁰ The primary motivation to give a placebo was the desire of the patient to receive a medication, followed by the intention to take advantage of placebo effects, and the by the will to avoid conflicts with patients or the need of telling them that all therapeutic options were exhausted. As for ethical attitudes, this systematic review found that the majority of health professionals found the use of placebo morally problematic, but that up to 50% considered it acceptable whether it was meant to benefit the patient.

A recent study with 1715 UK doctors found that 97% of the interviewed participants reported having used impure placebos at least once in their career, and 77% of using them frequently (at least once in a week), while only 1% do the same with pure placebos. Common reasons to prescribe them were: psychological treatment, because patient requested a therapy; to treat non-specific complains, and to calm patients (Howick et al. 2013b). This study also investigated more in depth the ethical attitudes of physicians, finding that—with respect to the prescription of pure placebos—66% thought that in certain circumstances they were ethically permissible; that 82% found them unethical whether they entailed deception; and that 90%

⁷⁰ Interestingly, in the studies in which it was possible for the physician to indicate what constituted a placebo, some indicated as “a placebo” the use of non-essential diagnostic procedures and physiotherapy (Fässler et al. 2010, 11); on the importance of this notion see (6.10.d).

considered them unethical whether they jeopardized the doctor-patient trust. Results for the case of impure placebos were similar (84%, 82% and 94% respectively).

In sum, deceptive placebos are still widely used in clinical settings for a variety of reasons that include doctors' attempt to mollify patients and satisfy their request for a prescription, as well as motives regarding the clinical utility of placebo treatments. In general, the vast majority of clinicians use "impure" rather than "pure" placebos. Ethical attitudes are polarized, but the majority of medical professionals seem to agree that placebos are in general ethically worrisome but they can be justifiable in specific circumstances to benefit patients.

(6.6) The ethics of deceptive placebos

Deceptive placebos can have limited effectiveness for treating a number of conditions such as pain, depression and irritable bowel-syndrome. Since in principle placebos are also cheaper than other effective medications, one could argue that deceptive placebos may in some cases provide an appealing therapeutic option. Moreover, empirical surveys show that deceptive placebos are still widely administered in clinical settings for different reasons. However, the use of placebos is fraught with all the moral quandaries typically associated with the use of deception in clinical settings. Are deceptive placebos justifiable in clinical settings? And if so, how can we identify those cases in which their use is morally permissible?

In the rest of this chapter I explore the ethics of deceptive placebos by applying the theoretical framework that I have elaborated in the first part of this dissertation. In general, the view that I will defend about the ethics of deceptive placebos is the same that I have defended with regard to the moral permissibility of other forms of deception in clinical settings: while deception and dishonesty are *prima facie* wrong, resorting to such practices is permissible only in exceptional cases; namely, in all those cases in which the proposal of using

a deceptive placebo could conceivably pass the tests of veracity, publicity, and public disclosure. This general perspective, I will argue, is to be understood in a stricter sense when applied to deceptive placebos. Other things being equal, clinicians should not use deceptive placebos unless they have *exceptionally* good reasons to do otherwise.

In order to defend this position in the next sections I will discuss arguments that have been elaborated to claim that (6.7) physical placebos are not ethically controversial because they can be administered in ways that are neither “open” nor “deceptive”; (6.8) and because many patients do prefer to receive deceptive placebos; (6.9) that deceptive placebos should be frequently used because they are always safe and often the best available treatment; (6.10) and that deceptive placebos ought to be categorically prohibited on precautionary grounds. As I will argue, each of these positions is wanting for some reason, but their shortcomings can all be avoided by applying the view that I have elaborated in part (I).

(6.7) Can placebos be administered in ways that are non-deceptive and yet not-open?

Usually, it is assumed that covertly administered placebos involve some form of deception. Accordingly, the ensuing ethical debate revolves around whether such deception may or not be justifiable under certain circumstances (Bok 1978; Brody 1982; Bostick 2008; Kolber 2007; Miller and Colloca 2009; Asai and Kadooka 2013; Foddy 2009). There is, however, another possible line of argumentation that consists in maintaining that it is possible to administer placebos in “non-transparent ways”, that is, in ways that are neither “open” (e.g., “this is a placebo”) nor deceptive (e.g., “this is morphine” whereas the pill is instead a placebo).

Scholars pursuing this line of argumentation usually start by questioning the definition of “deception” assumed at the outset of the discussion. Deception is then normally defined as “intentionally causing someone to have a false belief that the deceiver believes to be false”

(Carson 2010; see 2.1). Consider, however, the following way of introducing a placebo: “I am prescribing you a pill which research suggests can be of benefit to you. In your circumstances I have reason to believe that it will work, with a minimum of side effects” (Gold and Lichtenberg 2014). It is claimed that this disclosure is “not transparent”—because it does not openly inform the patient that the pill is a placebo— and yet it is also “not deceptive”—because the statement is not factually false: placebos can be clinically helpful and the physician may genuinely believe so (Cohen and Shapiro 2013; Gold and Lichtenberg 2014).⁷¹

It is important to appreciate that if these authors were right, then they could argue that a clinician willing to prescribe a (non-transparent) placebo could legitimately do so without the need of publicly justifying his/her choice. Since there is no deception involved, then there are no risks for patients’ autonomy or trust, and therefore the proposal of using placebos in this way would not need to pass through the tests of veracity, publicity and of public disclosure to be morally justified. But is this line of argumentation successful in avoiding the traditional hurdles of the moral debate over the permissibility of prescribing placebos to patients?

I argue that is not, and for the following three reasons. First, advocates of the “non-transparent” use of placebos have a too restricted conception of clinicians’ obligations of veracity. As I have argued in chapter 2, this obligation does not entail only a negative obligation to refrain from lying and deception, but also a positive duty of providing all those information that are sufficiently relevant for patients. Arguably, the fact that one is assuming or not an active medication is one of those information that are potentially relevant from a medical point of view. As noted by Kolber (2009, 25), “If a person ends up in the emergency

⁷¹ As Cohen and Shapiro (2013, 698) have recently argued, “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”. Similarly, Gold and Lichtenberg (2014, 221) have defended the same view in a recent article where they claim 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’ [...] if we define deception as ‘intentionally causing someone to have a false belief that the deceiver believes to be false’, then for the physician who genuinely believes in the therapeutic qualities of the placebo treatment, it would not be considered deception as well”.

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". It is thus reasonable to argue that the nature of one's medication is one of those essential pieces of information that fall under the duty to inform patients in order to respect their autonomy. Accordingly, clinicians using "non-transparent" placebos would still be dishonest, 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 medical information.

Secondly, it can be argued that not informing the patient that the prescribed medication is a placebo qualifies as an act of deception by *omission* because the clinician would fail to correct a false belief entertained by the patient, i.e., the belief "that doctors give only active medications" (see 2.1). One could reply that clinicians cannot be sure about what beliefs are harbored by their patients, and thus, other things being equal, that they cannot have an intention to deceive them by omission. This reply, however, is unconvincing. As Bok has noted, the context in which any therapeutic encounter takes place is not neutral as to the beliefs that both parties can be reasonably expected to entertain:

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) objected to the proposal of administering non-transparent placebos on the ground that "a true impression, not certain words literally true, is what we must try to convey" and that what counts as "deceptive" may be dependent on the norms and expectancies of a particular social setting (Brody 1982). Today patients may reasonably expect

that all the medicines that doctors prescribe to them have been tested and approved for their specific efficacy. To contravene this widely shared expectation counts as deception, even if the words uttered by the clinician are sufficiently vague as not to be literally false.⁷²

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 ones, namely, that concealment tends often to “spill over” into deception and lying (see 2.2). Assuming that the physician will not be able to write a prescription for a placebo pill to be dispensed by a pharmacy, how will she present the treatment to the patient? How will the bottle of pills be labeled? What if the patient starts asking questions about the medication contained in those pills? What if she wants to double-check online what sort of medication she has been suggested to take? Therefore, even if the initial statement may not be literally deceptive—although it can be *contextually* so—there is always a risk that it could open the way for explicitly deceptive practices, requiring open lies where before there was only strategic concealment.

In sum, 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 open nor deceptive. It is not possible to have the placebo cake and eat it too: either the administration of a placebo is fully open-label, or else it is dishonest and it requires to be justified according to the view that I have elaborated in part (I).

⁷² For this reason I disagree with both O’Neill (1984) and Barnhill (2011) that it might be a promising line of defence for deceptive placebos to argue that concealing the nature of an intervention is sometimes compatible with the respect of patients’ autonomy. In particular, O’Neill has argued that patients cannot be informed about every aspect of the treatments they receive, and therefore that they “can no more be asked to consent to every aspect of treatment than citizen can be asked to consent to every act of government. Respect for autonomy requires that consent be possible to fundamental aspects of actions and proposals, but allows that consent to trivial and ancillary aspects of action and proposals may be absent or impossible [...] However, some non-fundamental aspects of treatment to which consent has been given may have to include elements of deception and coercion. Use of placebos or of reassuring by inaccurate accounts of expected pain might sometimes be non-fundamental but indispensable and so permissible deceptions” (1984, 176).

(6.8) Deceptive placebos and patients' preferences

In his formidable defense of the use of deceptive placebos, Adam Kolber (2007; 116) has argued that the provision of deceptive placebos might actually be consistent with some patients' preferences. Other authors have similarly maintained that some patients—if not the majority of them—may actually “want to be locally manipulated [through a placebo] for the sake of achieving [a] larger goal”, that is, symptomatic relief (Cohen and Shapiro 2013, 703).

At present, empirical evidence on patients' attitude toward the clinical use of placebos is scarce. A 1993 Swedish study found that 25% of interviewed patients agreed completely or for the most part that physicians ought to prescribe more often placebos on their own initiative, while 63% agreed that it is acceptable to administer a placebo to a dying cancer patient if there is little chance that she will discover the truth (Lynöe et al. 1993). More recently, a survey in US patients found that “most respondents (50-84%) judged it acceptable for doctors to recommend placebo treatments [...] Only 21.9% of respondents judged that it was never acceptable for doctors to recommend placebo treatments” (Hull et al. 2014).

These findings may reinforce arguments in favor of deceptive placebos in two ways. First, they can reinforce the case for paternalism by suggesting that “placebo deception” constitutes only a minor infringement of patient's autonomy (Kolber 2007). Second, they can mitigate the concerns about the effects of deception on trust. If a patient considers morally appropriate the use of deceptive placebos, then, when she discovers that her clinician had given her a placebo, she might not consider such deception a too severe breach of her trust. Perhaps some patients might even consider it as a sign of the doctor's commitment to their wellbeing. Similarly, if the vast majority of patients support the use of deceptive placebos, using deceptive placebos would likely not compromise the social status of medicine.

Taking into account patients' preferences is crucial in any context, but it is especially important in relation to the ethics of deception. In fact, knowing patients' preferences may shape the process whereby clinicians articulate their reasons about the moral permissibility of using deceptive placebos in one way or the other, as such preferences could determine both the way in which one could take the test of publicity and the way in which the use of deceptive placebos could eventually be disclosed. If patients are overwhelmingly in favor of deceptive placebos, then one might conclude that clinicians would be often ready to defend their use in public; if patients have the opposite opinion, instead, clinicians could reasonably be more cautious. Also, knowing patient's preferences may lead to different conclusions about the moral permissibility of a deceptive act in those cases in which it is not possible to directly ascertain the preferences of a specific patient (for example, because it would reduce the therapeutic effectiveness of the placebo), and in which the clinician relies on her knowledge of what other reasonable people belonging to the same cultural group would do.

Thus, it is important to conduct more empirical studies in order to better ascertain patients' preferences regarding the clinical use of deceptive placebos. However, it is also important to underscore two important points that are often overlooked by commentators who use studies about patient's unexpressed preferences to support the case for deceptive placebos. First, meeting patients' unexpressed preferences is not the same as to respect patients' autonomy. As noted by Barnhill (2011, 228), the fact "that a patient's unexpressed preferences are met doesn't mean her autonomy is respected because respecting her autonomy requires letting her make an actual informed decision about her treatment". Thus, even if by using a deceptive placebo a clinician would eventually be making what that patient would consider to be right for her, this clinician would nonetheless violate this patient's autonomy and right to informed consent. As the different levels of the test of publicity make explicit, respecting patient's autonomy and meeting her preferences are two important and yet distinct desiderata for anyone supporting the case for a deceptive act.

Second, patients' unexpressed preferences may not be predictive of their actual reactions. As stressed in part (I) often we tend to appraise the moral consequences of a deceptive act differently depending on which of the two perspectives we assume: the one of the deceiver, or the one of the deceived. If this is true, then patients may agree that physicians should use placebos in certain circumstances, but may nonetheless consider a deception as a breach of *their* trust if they found out that *they* are the ones that have been deceived. Interestingly, the above-mentioned US study found also that most of the "respondents valued honesty by physicians regarding the use of placebos and believed that non-transparent use could undermine the relationship between patients and physicians" (Hull et al. 2014). This suggests that while not every patient considers the use of deceptive placebos as a breach of trust, some will, and most patients would still consider this practice to be problematic whenever the deception is uncovered.

In sum, while empirical knowledge about patients' preferences regarding the use of deceptive placebos may influence how we articulate the reasons as we evaluate the moral permissibility of a specific case, this knowledge must always be used with caution; in particular, it can never be considered a good excuse for not respecting individual autonomy, and it may not be entirely predictive of patient's actual reactions.

(6.9) A critique of Foddy's view that clinicians have a "duty to deceive"

In a 2009 target article for the *American Journal of Bioethics*, Bennett Foddy has argued that there are many cases in which it would be ethical—if not a *duty*—for clinicians to use deceptive placebos in clinical contexts. In particular, Foddy's bold defense of the clinical use of

deceptive placebos is grounded on the assumption that they are “always safe, often effective, and sometimes necessary”⁷³

In this section I argue that Foddy’s proposal is seriously flawed, might lead to severe consequences for both individual and public health, and should therefore be briskly refuted. While his argument is fallacious in a number of ways, I shall focus my critiques only on two of the claims motivating his position: (i) the view that placebos are “necessary” whenever they are the “best available treatment”; (ii) and the assumption that placebos are “always safe”.

(6.9.a) When is a deceptive placebo the “best available treatment”?

At the outset of this discussion, it is important to appreciate the extent to which Foddy is willing to defend the clinical use of deceptive placebos. As he explains, his defense regards all those cases in which deceptive placebos are “necessary” because they can be considered to be the “best available treatment” (2009, 5-7). These cases include not only the use of placebo to treat conditions for which empirical studies suggests that their efficacy may sometimes match that of the standard of care (e.g., depression or IBS), but also those cases in which

Patients [...] have treatable disorders but [...] are nevertheless untreatable [...] roughly half the time a patient presents himself to a doctor, a firm diagnosis cannot be made [...] The untreatable patient can be prescribed a placebo, or sent away empty-handed. The latter course of action neglects an opportunity to alleviate the felt discomfort of the patient’s symptoms, and it may leave patients feeling shortchanged [...] Since deceptive placebos are sometimes the best treatment, it is possible that they may be prescribed in a manner that is ethically defensible (2009, 6).

If Foddy’s defense succeeds, according to this quote, it would be ethical for clinicians to prescribe deceptive placebos to every patient who is otherwise untreatable. These cases

⁷³ In this article, Foddy advances also other surprising claims, such that deceptive placebos “not subject to the same moral objections that face other forms of deception in clinical practice and medical research” (2009, 4). I will not discuss these other problematic aspects of his view; for a critique see Kolber (2009).

would be extremely common not only in clinical practice—where many patients present vague, symptomatic and medically unexplained symptoms—, but also in all other cases in which treatments are unavailable. In the light of empirical data about the current clinical use of placebos (see 6.5), Foddy’s proposal would always justify the practice of prescribing placebos to patients who pretend a prescription but for which a firm diagnosis cannot be made. Therefore, if Foddy were right, we should expect clinicians to use deceptive placebos on a fairly regular basis, as they would often be the only option available and thus the “best available treatment”.

This latter conclusion, however, mistakenly conflates the concept of “best available treatment” with the concept of “best clinical option”. In medicine, and especially in contemporary medicine, to prescribe a treatment might sometimes be the best available clinical option; other times, instead, the best “treatment” for a patient is simply to receive “no treatment” at all. Clearly, no clinician “has a duty” to prescribe a treatment to a patient simply because otherwise she would walk-away empty-handed. The role of clinicians is not just that of dispensing pharmaceutical treatments—“active” or “placebic” ones depending on the case—but also that of providing care and support in order to select the best course of action that would allow to preserve and foster the patient’s health and wellbeing.

Indeed, sometimes to prescribe a “treatment”, even an active one, is the suboptimal choice for doctors. As Schenker et al. (2009) argued, whenever doctors are facing an uncertain diagnosis of medically unexplained symptoms, they always have another available option: to acknowledge their uncertainty. Medicine is not an exact science, and sometimes clinicians can be reasonably unsure about making a diagnosis or prognosis. Physicians may thus acknowledge that sometimes patient’s symptoms are both real and puzzling, expressing their concerns while at the same time showing empathy with the patient’s condition (Epstein et al. 2007). For example, instead of providing antibiotics for a viral infection or a cold simply to

satisfy the patient's desire of a medication, a clinician can always state, "I know that this kind of cold is bothersome, and I *wish* we had a medicine for it. Sadly, we still don't have it".

Aside from the fact that clinicians' *prima facie* duty of veracity would in any case compel clinicians to tell the truth to patients even in the case of an uncertain diagnosis or in the absence of an effective treatment, by acknowledging their uncertainty clinicians can achieve other ends that would otherwise be precluded by the automatic prescription of a deceptive placebo; these include: the exploration of patients' concerns, beliefs and preferences; the discussion non-pharmacological treatments (e.g., to maintain a high hydration in the case of a bad cold); and the enacting of shared decision-making (Schenker et al. 2009). Therefore Foddy's claim that deceptive placebos are often the best clinical option because no other treatment is available is at best mistaken: while facing uncertainty in medicine doctors have always the option of being honest with their patient, hence sharing rather than dumping the responsibility of deciding how to best cope with untreatable conditions.

(6.9.b) Are deceptive placebos "always safe"?

Another mistaken assumption in Foddy's argument is that "since placebos are inert, it is natural to expect that they are completely harmless, unlike active medications that frequently elicit unwanted side effects [...] there is no reliable evidence to suggest that the beneficent use of placebos is unsafe" (2009, 5). Much of Foddy's argument depends on the questionable premise that since placebos are *always safe* and *sometimes effective*, then there is always a favorable presumption to support their administration: other things being equal, they will be at best clinically useful and at worse completely innocuous. This claim, however, fails insofar as placebos may harm individual patients and society in a number of important ways.

First, *contra* Foddy, placebos are always relatively “inert”, but never absolutely so. This is true of both “pure” and “impure” placebos, because a placebo is always “a placebo” relatively to a certain condition and according to a certain biomedical theory. Saline injections are not “inert” for rehydrating someone in needs of fluids; sugar pills are not “inert” for people who have diabetes; and lactose tablets are not “inert” for people who are intolerant to lactose. The risks that a deceptive placebo would lead to unwanted side effects are even greater in the case of the prescription of “impure” placebos. In fact, even the prescription of a “homeopathic” dosage of an effective medicine may unpredictably interact with the effects of other substances, and it can always be risky or defective on its own (e.g., the “homeopathic” doctor may mistakenly use a minimal and yet dangerous highly toxic substance). Furthermore, deceptively administered placebos can sometimes induce psychological addiction, as in the case of CG discussed in the introduction (Baumrucker et al. 2011).

Furthermore, there are other risks related to the prescription of a deceptive placebo, the most important of which is the possibility to overlook present symptoms (Bok 1978; Brody 1982). Patients who “walk away” thinking that they have already found an effective medication for their ailments may not look for a second opinion, hence precluding the possibility of undergoing more diagnostic exams. Another harm of deceptive placebos comes in the form of all the indirect costs associated with the practice of buying and consuming them: as noted by Brody (1982), if patients can get placebos for free, then they will uncover the deception and the deceptive placebo would become ineffective; if, instead, they are required to pay for them, then they would have to pay no less than it would cost them to pay for standard medications. In any case, the prescription of deceptive placebos would have its own “cost”, either in terms of interpersonal trust and effectiveness, or in monetary terms.

Aside from the costs for each individual patient, however, deceptive placebos have also important costs for society. Prescribing “impure” placebos, in fact, may have both direct and indirect consequences for public health. As for the direct consequences, prescribing

antibiotics in the form of impure placebos make bacteria more resistant to them, hence leading to potentially severe consequences for public health in the long run.⁷⁴ As for the indirect consequences on health, the cost of prescribing unnecessary treatments in the form of impure placebos is likely to be anything but trivial. As Bok noted (1972, 21) “A great many diagnostic procedures that are known to be unnecessary are undertaken to give patients a sense that efforts are being made on their behalf. Some of these carry risk; many involve discomfort and the expenditure of time and money”. If the concept of “placebo” is extended to all kinds of procedures that are unnecessary prescribed to satisfy patient’s request that “something be done”, then costs and harms entailed in Foddy’s proposal becomes obvious.

Finally, there is a subtler kind of harm that deceptive placebo can have as they contribute to the medicalization of society. Prescribing a deceptive placebo whenever there is no other treatment available to cope with unexplained symptoms promotes the wrong belief that there is “a pill for every ill” (Miller and Colloca 2009), and thus that everything can be cured or treated simply by quaffing some colored pill. In this respect, Cabot noted:

The majority of placebos are given because we believe that the patient will not be satisfied without them. He has learned to expect medicine for every symptoms and without it he is simply won’t get well. True, but who taught him to expect a medicine for every symptom? He was not born with that expectation. He learned it from an ignorant doctor who really believed it [...] it is we physicians who are responsible for perpetuating false ideas about disease and its cure [...] and with every placebo that we give we do our part in perpetuating error, and harmful error at that (Cabot 1903, 348).

In this classical paper on truth telling and lying in medicine, Cabot strongly objected to the practice of prescribing “innocuous” treatments for providing “mental relief” to patients pretending a prescription. In Cabot’s view, clinicians had to appreciate that in these cases truth

⁷⁴ The provision of antibiotics for viral infection may have negative consequences at the level of public health. It also represents a paradigmatic case of impure placebo use in clinical contexts. It is important to note, however, that this questionable practice can be also understood as a simple instance of medical malpractice, rather than as an instance of an unjustifiable use of a placebo. Simply put, doctors must not prescribe medicines for ailments for which they are known to be ineffective. This latter phrasing has the advantage of being more direct and more readily put into the context of already existing and well-received guidelines. Accordingly, if the objective of policy-makers or guidelines is that of regulating the use of antibiotics, it is probably better to phrase this issue in terms of medical malpractice rather than in the terms of ethics of using clinical placebos.

telling is likely to have more beneficial effects than lying and that the act of promoting false beliefs about health and disease is just another way of harming patients in the long run.⁷⁵

Foddy's arguments that deceptive placebos are "always safe" and "often the best clinical option" are thus flawed. Placebos can harm both patients and society in direct and indirect ways, and clinicians dealing with an uncertain diagnosis have always the possibility of choosing to be honest instead that prescribing a deceptive placebo not to let patients walk-away empty handed. Thus, in addition to other concerns for patient's autonomy and trust that accompany any proposed act of clinical deception, clinicians ought to be even more careful in considering the use of placebos because of the additional risks associated with their use.

(6.9.c) Reinforcing the negative presumption against the use of deceptive placebos

According to the view that I have defended in part (I) clinicians have a *prima facie* duty of veracity in their professional communications. Other things being equal, there is a negative presumption against the use of dishonest communication. This presumption derives from the moral implications that dishonesty have for the respect of patient's autonomy and the preservation of trust between doctor and patient. Providing a compelling moral justification to defend a deceptive act is always demanding, as those who are defending it should, in any one case, to argue that such proposal would conceivably pass the tests of veracity, publicity and of public disclosure. How is this perspective applicable to the case of deceptive placebos?

⁷⁵ Interestingly, however, Cabot himself did recognize that in very exceptional circumstances it might be morally permissible to prescribe a deceptive placebo only to meet patients' request of a medication: "No patient whose language you can speak, whose mind you can approach, needs a placebo. I give placebos now and then [...] to Armenians and other with whom I cannot communicate, because to refuse to give them would create more misunderstandings, a false impression, than to give them. The patient will think that I am refusing to treat him at all; but if I can get hold of an interpreter and explain the matter, I tell him no lies in the shape of placebos" (Cabot 1903, 348).

First, the proposal of using a deceptive placebo would have to pass the test of veracity. In order to do so, one must be able to argue that, in those circumstances, the use of a deceptive placebo is the only plausible option available to achieve a certain objective. However, in most of the cases for which deceptive placebos are currently used, it is reasonable to conclude that such proposal would fail to pass the TOV. As the analysis of Foddy's first argument shows, clinicians who prescribe deceptive placebos to patients for which no firm diagnosis could be made are systematically ignoring that they always have another plausible and truthful option at hand: acknowledging their uncertainty by telling the truth to patients. If the goal is that of fostering patients' wellbeing, then usually there are many other options available to clinicians other than the prescription of a deceptive placebo.

Second, most of other proposals would fail to pass the test of publicity, either because of their unfavorable risks-benefits ratio, or because they would be publicly indefensible. Let us begin with this latter category of cases. Clearly, the proposal to use a deceptive placebo to "mollify a patient" would conceivably fail the test of publicity at some level. This is the case, for example, of a clinician who prescribes a deceptive placebo either because she is unsure about the diagnosis in that specific case, or because she wants to quickly get rid of a complicated patient, for example of someone who repeatedly shows up with a plethora of vague psychosomatic symptoms. Here the clinician does not resort to "benevolent" deception, but to deception *simpliciter*, as the act is finalized to benefit only the clinician, i.e. the deceiver.

Arguably, in these cases, the use of deceptive placebos is unethical as it contravenes the very scope of the medical profession, that is to say, to help others in need of medical assistance and care. Who would excuse a physician who systematically lies to patients simply on the grounds that she did not want to lose too much time attending to their questions and needs? Which professional body of peers would be ready to defend the conduct of this clinician in front of all other citizens? In these cases the test of publicity, if properly implemented, would rule out those proposals that are based on purely selfish motivations.

Other times, instead, the proposal to use a deceptive placebo would not pass the test of publicity because of its unfavourable risk-benefits ratio. This may be so in most of the cases in which a placebo is given only to satisfy patients' need of a prescription with the sole intent of providing "mental relief" (e.g., to calm down an anxious patient). Here the considerations of the individual and societal risks entailed in the use of deceptive placebos is likely to stop the articulation of the reasons in favour of the proposed deception either at the level of their balancing, or at the level of the public justifiability of this practice. Who would be ready to defend a trade-off between the "mental relief" of a few and the prospective increase of health-care costs for everyone or, in the case of antibiotics, with the risk of creating more resistant bacteria? (As I discuss in the next section, the other case in which the use of deceptive placebos is justified for therapeutic purposes is instead more controversial.)

To sum up, in the vast majority of the cases the two main rationales for which deceptive placebos are currently widely prescribed to patients in clinical settings appear to be morally indefensible according to the view that I have proposed. Other things being equal, it is unethical for clinicians to use deceptive placebos, especially if their intent is to mollify patients and/or to satisfy their request for unnecessary or unavailable prescriptions. If what I have argued so far I correct, then professional organisations such as the AMA, professional organisations, and national institutions should take adequate measures to limit and prevent the further use of deceptive placebos in these cases.

(6.10) A critique of the view that deceptive placebos are always unethical

In sharp contrast with the data about the use of placebos in clinical settings, current ethical guidelines tend to endorse a policy of "categorical prohibition" with respect to the clinical use

of deceptive placebos. For example, in 2006 the American Medical Association (AMA) released its placebo policy in the form of an official “Opinion” in which it stated,

[...] In the clinical setting, the use of a placebo without the patient’s knowledge may undermine trust, compromise the patient- physician relationship, and result in medical harm to the patient. Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use [...]

According to this position, using deceptive placebos in clinical settings without patients’ consent is never permissible. Over the years several commentators have defended similar positions and therefore the AMA Code of Medical Ethics is not alone in advocating a categorical ban of deceptive placebos in clinical settings (Asai and Kadooka 2013; Brody 1982). In any case, defenders of the categorical view do not deny that deceptive placebos may have clinical benefits; rather, they argue that deceptive placebos have a series of short and long-term implications—e.g., for trust, respect of patient’s autonomy and patients’ or public health—that once factored in justify a categorical ban of their use on precautionary grounds.

In recent years the AMA placebo policy has been subjected to several critiques targeting its problematic definition “of placebo” and the extent to which it succeeds in protecting patient’s trust, respecting patient’s autonomy, and ensuring medical benefit to the patient (Kolber 2007; Foddy 2009; Barnhill 2012). In this section I will focus only on the question of whether a categorical position provides a satisfying starting point to think about the ethics of deceptive placebos in clinical contexts. Siding with other critics, I will argue that the AMA placebo policy is too strict and overinclusive: there are cases in which using deceptive placebos has high prospective benefits, minimal consequences for patients’ autonomy, and, provided other conditions are met, a low risks to disrupt patients’ trust. However, while in these cases the use of deceptive placebos seems to be desirable and morally justifiable, it would be unethical and prohibited under the AMA placebo policy.

(6.10.a) Defending the use of deceptive placebos for therapeutic purposes

The first case questioning the rationale behind a categorical ban of deceptive placebos regards the possible scenario in which a deceptive placebo has high therapeutic utility. In absence of contrary empirical evidence, I assume deceptive placebos to have at best a limited, highly variable, and typically short-term clinical effectiveness. However, in the case of chronic or severe conditions with life impairing, symptomatic manifestations (e.g., chronic low-back pain), if no other clinical options are available, then even the perspective of a limited symptomatic improvement may translate into a significant difference for patients' quality of life. Consider the following scenario:

During a bad bout of depression, a patient begins psychotherapy and antidepressants. The regimen works quite well for several weeks, and the depression gradually gets under control. Soon after, however, doctors discover that the patient has an unrelated liver condition that requires him to discontinue his use of antidepressants. After ceasing medication, the patient's mental health quickly declines. The patient's psychiatrist is aware of considerable medical literature finding powerful placebo effects in the treatment of depression and knows of several researchers who claim that pharmaceutical antidepressant may not be much more effective than placebos. The psychiatrist, therefore, provides the patient with two weeks worth of placebo pills and misleadingly states that they are antidepressant that are likely to help the patient without causing any worrisome side effects. After two weeks, the patient reports feeling much better (Kolber 2007, 120).

In this hypothetical scenario it is clear that the use of a deceptive placebo had a significant therapeutic benefit. Was it also morally justifiable? To answer this question let us apply the view elaborated in part (I), and ascertain whether the psychiatrist's proposal would conceivably pass the tests of veracity, publicity and of public disclosure.

First, for this act of deception to be justifiable, we must see whether it could be defended as the best plausible course of action to achieve the given objective, which, in this case, is the control of patient's depressive states. In the case above, given that other medications were no longer an option, it could be argued that psychiatrist had not other plausible means at his disposal to control for the patient's depressive states.

Second, the proposal of using a deceptive placebo would have to pass the test of publicity. Would the psychiatrist be ready to defend her behavior in front of a commission or a court of law? Assuming in this case that: the depressive states were bad enough; that the administered placebo was a “pure” rather than a “impure” one and had no severe health-risks; that the way in which the misleading disclosure had been devised minimized the use of lying; that the paternalistic infringement of patient’s autonomy was judged to be justifiable in the light of the prospective benefits; that other colleagues as well as the patient’s wife eventually judged the use of placebos to be justifiable in this case; and that, according to the long-standing relationship between that patient and the psychiatrist the latter could confidently assume that the patient would in principle not oppose the use of the deceptive placebo; *then* it is also reasonable to conclude that, in this specific case, the psychiatrist would be ready to defend in public his choice. Accordingly, it could have been morally permissible for the psychiatrist to keep the placebo secret in this case.

Determining only the moral permissibility of the deceptive act, however, is never enough as the deceiver has also the moral responsibility of adopting the appropriate technique of publicity to minimize the potential harm for the patient’s trust and autonomy. In this case, after the two weeks the psychiatrist might consider revealing the deception to the patient, for example explaining that this experience revealed his “own ability to work through his emotional problems and shows that it will now better manage depression with psychotherapy alone”. By resorting to a retrospective and direct technique of publicity, the psychiatrist in this example can at least partially restore the patient’s autonomous agency as well as preserving the bond of trust in the light of the exceptionality of the circumstances and of the willingness to rebuild a therapeutic relationship based on honesty.⁷⁶

⁷⁶ Interestingly, while discussing this case, Kolber (2007, 121) refers to Bok’s analysis and hint at the need of implementing in this case what I have defined as the “techniques of publicity” as he observes, “[t]o make the case more appealing, we could add a variety of precautions on the deceptive use of placebos. For example, we could require physicians: (1) to consult with one or more other physicians or with an ethics committee before using a

Therefore, by deploying the appropriate technique of publicity, is reasonable to hold that clinicians may resort to deceptive placebos in a way that is highly beneficial for patients without compromising their individual autonomy and trust in ways that would be *prima facie* unethical. These cases may be extremely rare, but they are not unconceivable or impossible, even if we assume that deceptive placebos have in general only a limited clinical effectiveness. Thus, while the view that I have defended is able to discriminate these rare cases from those in which it would be unethical to use a deceptive placebo, a categorical ban would instead force the psychiatrist in the above example to choose among two suboptimal alternatives: either to suspend altogether the antidepressant medications for the patient, or to propose an open-label placebo which might have a reduced (or none) clinical effectiveness.

(6.10.b) Defending the use of deceptive placebos for diagnostic purposes

The second scenario in which the use of deceptive placebos may be morally defensible is when they have high diagnostic utility (Kolber 2007; Rorty and Frankel 2009). While this case is the perhaps the least controversial, it is also the least discussed within the placebo literature. Consider the following scenario: a clinician is unsure about whether one of her patient has epilepsy—a neurological disorder that might induce seizures—or a psychological condition which is able to induce epileptic-like, pseudoseizures. She is aware that “[t]he cost of pseudoseizures misdiagnosed as epilepsy can be extremely high, from both a financial and a psychosocial standpoint, with repeated hospitalizations, unnecessary medications, loss of work, loss of driving privileges, and strain on interpersonal relationships all contributing to overall disability” (Slater 1995, 36).

deceptive placebo, (2) to document the use of a deceptive placebo, perhaps in hospital or patient records, (3) to obtain the informed consent of a relative or guardian if possible, and (4) to reveal to a patient that he was secretly given placebos within a reasonable time after commencing treatment.”

There are two effective ways to distinguish epileptic seizure from pseudoseizures. The first one is electroencephalography. This method is reliable but requires the patient to be actually connected to the machine as s/he is having an attack. The problem is that epileptic seizures are unpredictable, and to monitor a patient for a long time can easily become prohibitively expensive. The second method, then, is to use a deceptive placebo. One study (Slater et al. 1995, 509) showed that it is possible to reliably induce pseudoseizures in patients by providing a saline injection introduced by the following script:

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

Knowing that researchers in that study were able to distinguish reliably all cases of pseudoseizures, the clinician decides to use the same procedure to diagnose the patient by administering with the same script an injection of saline solution, i.e., a deceptive placebo. Is this practice morally justifiable according to the view that I have defended?

First, we should again consider the test of veracity. In this case it is clear that if the objective is that of being able to identify pseudoseizures, then the deceptive placebo is the only plausible option available, as the truthful option of encephalography has prohibitive costs and an open-label placebo would not work in this case. Second, let us assume that the clinician concludes that it is justifiable to infringe patient's autonomy on the grounds that a correct diagnosis would allow the fostering of patient's long-term autonomy; that the placebo to be used has low-risk; that the patient's caregivers and colleagues agree that it might be reasonable to resort to situational dishonesty given the prospective gains in terms of health and wellbeing; and that this patient is known to be prepared to do anything to find a way of controlling her episodic seizures. In principle, this is a scenario in which the proposal to use a deceptive

placebo can conceivably pass both the tests of veracity and of publicity. Lastly, the clinician should select the most appropriate technique of publicity. As in the previous case, also in this latter scenario the best option is likely to be a retrospective and direct disclosure of the deception once the diagnosis has been made.

Therefore, there are cases in which the use of a deceptive placebo in clinical settings for diagnostic purposes would conceivably be justifiable. Applying the ethical guidelines which enforce a policy of categorical prohibition on precautionary grounds would in this case force the clinicians to choose between one of the two alternatives: either risking of treating a patient for the wrong disease with potentially great harms and costs, or provide no treatment at all. These two scenarios are clearly less desirable than the one in which the clinician resort to a one-time deceptive placebo after having properly articulated all the relevant reasons pros and cons this practice, and after having selected the most appropriate means to minimize the infringement of patient's autonomy and the possible damage for trust. Hence, in this case, a clinician following the perspective that I have elaborated would take a better decision with respect to another clinician who instead applies a categorical ban to all deceptive placebos.

(6.10.c) A limited plea for the adoption of negative informed consent

In the two examples discussed above, the best option for the clinician was in both scenarios that of resorting to a direct and retrospective technique of actual publicity. In principle this is a suboptimal choice, as it would be better to deploy in each case a technique that is *prospective* rather than *retrospective*. The AMA placebo policy seems to acknowledge this point when it states that a placebo used for diagnostic and therapeutic purposes

may still be effective if the patient knows it will be used but cannot identify it and does not know the precise timing of its use. A physician should enlist the patient's cooperation by explaining that a better understanding of the medical condition could be achieved by evaluating the effects of

different medications, including the placebo. The physician need neither identify the placebo nor seek specific consent before its administration. In this way, the physician respects the patient's autonomy and fosters a trusting relationship, while the patient still may benefit from the placebo effect (Bostick 2008).

The idea of this quote is that patients may consent in advance to the proposal of using placebos for diagnostic and therapeutic purposes, while at the same time waiving the right of being specifically informed about the timing of the placebo administration. In this way it could be argued that patient's autonomy is respected because the patient has actually consented both to the use of placebos and to *not* receive specific information about their use.⁷⁷

Shaw (2009) has developed a similar view according to which placebos can be ethically administered to patients if those patients have previously and explicitly consented *not* to receive certain information about the chemical composition or efficacy of their prescriptions. Shaw's view is grounded in Kihlbom's proposal (2008) of complementing the framework of informed consent (IC) with the possibility for patients to express a preliminary "negatively informed consent" or (NIC). Contrary to the prevailing model in which patients need to be told whether or not they are receiving a placebo (see *infra* 6.3), in the NIC model a patient would instead give "his/her voluntary and explicit consent to undergo the treatment and express[es] his/her voluntary and explicit wish not to have more information" (Kihlbom's 2008).

By implementing a NIC approach, it would be possible for patients to autonomously decide whether they want to receive all the relevant information about their treatments, or

⁷⁷ A similar proposal has been advanced by Miller et al. (2013) for research contexts, as they suggest the possibility of adopting an approach of "authorized deception"; in their words: "However, participants can be informed prior to deciding whether to volunteer for a study that the experimental procedures will not be described accurately or that some features of these procedures will or may be misleading or deceptive [...] This approach, which we call 'authorized deception', permits research participants to decide whether they wish to participate in research involving deception and, if so, to knowingly authorize its use. When deception of study participants is necessary and justified by the scientific value of the study, the use of authorized deception makes the process of deceptive research transparent. Participants are informed that they will be misled or deceived, though obviously the exact nature of the deception cannot be disclosed. They are assured that the research has been reviewed and approved by an ethics oversight committee that has no vested interests in the research in question, and that no important risks, other than the risks of the deception itself, have been concealed. Finally, they are informed that debriefing will occur" (Miller et. al. 2013, 272-273).

entrust their clinicians with the decision about what needs to be revealed in each case in to achieve the best balance between autonomy and beneficence. They can at any time request more information or withdraw their NIC in favor of the standard IC approach. The NIC model is appealing because it enhances patients' autonomy in two respects: first, because it opens the possibility for patients to decide between more therapeutic options (e.g., standard or placebic ones); second, because through this choice it gives the patient more control over her decision-making role (Barnhill 2012, 235).

The NIC approach may thus open new diagnostic and therapeutic possibilities for clinicians considering the clinical use of placebos. After securing a valid NIC, clinicians could introduce a placebo by saying "this pill has no side-effects, but studies have shown that the more I tell you about how it works, the less effective it will be" (Shaw 2009, 98). If the patient has previously negated the NIC or she now decides to ask more information about the features of this pill, then the clinician would still provide a truthful disclosure, revealing that the pill is a placebo and perhaps explaining how it can still have some clinical effectiveness.

Shaw's proposal of implementing the NIC to improve the way in which clinicians may decide over the clinical use of placebos is appealing. However, it also has important limitations. First, the NIC approach ought to be grounded in the trust between a physician and her/his clinician, and thus is more readily implemented in context in which there is a personal therapeutic relationship rather than in those contexts in which the doctor-patient relationship relies more on the "elegant anonymity of medicine". Second, warning in advance patients that they might receive a placebo may be self-defeating: the simple fact of being unsure about whether the prescribed medication is a placebo might reduce both the therapeutic and the diagnostic utility of all placebos. More importantly, suspecting than one might be on a regime of placebo medication may drastically reduce patients' compliance with other effective medicines, as well as reducing their overall effectiveness, which is likely to be a function of both their specific efficacy and of placebo effects. Fourthly, there are cases in

which it would be in any case impossible to obtain a NIC in advance, and in which clinicians would be anyway forced to decide whether or not a deceptive placebo is morally permissible.

Therefore, while the NIC is in itself a interesting proposal which might sometimes result in the identification and implementation of better prospective techniques of publicity, more research is needed to ascertain how such approach would impact the therapeutic and diagnostic utility of otherwise deceptively administered placebos, and, in any case, it would not entirely solve all the moral dilemmas over the moral permissibility of deceptive placebos that clinicians would be required to face in clinical contexts.

(6) Summary

In this chapter I have explored the ethics of deceptive placebos, arguing that the perspective that I have elaborated in part (I) of this dissertation provides a better starting point to think about moral dilemmas involving the provision of deceptive placebos than other alternatives. In particular, I have defended a position for which the *prima facie* duty of veracity that clinicians have in their professional communication should be interpreted as being particularly strict in the case of deceptive placebos. In fact, in addition to other concerns about the respect of patient's autonomy and the preservation of the trust between doctor and patient, deceptively administered placebos may also harm patients and society in different and significant ways.

Contrary to the still widely spread practice of administering impure placebos to patients, I have therefore argued that it is unethical to prescribe deceptive placebos in the vast majority of cases. In particular, administering a placebo to mollify a patient or to provide only some mental relief can hardly be regarded as being a justifiable practice—even if some or the

majority of the patient have an unexpressed preference in favor of being deceived. Other things being equal, clinicians should not prescribe or give deceptive placebos to patients.

In difference to categorical policies and positions, however, I have also defended the claim that there could be exceptional cases in which using a deceptive placebo for therapeutic or diagnostic purposes can be a morally justifiable practice. These cases are the cases in which the proposal to adopt such a deceptive technique would conceivably pass the tests of veracity, publicity, and of public disclosure. Finally, I have analyzed Shaw's proposal of implementing a "negatively informed consent" approach to complement the standard model based solely on informed consent, underscoring its potentialities as well its intrinsic limitations.

7. The Ethics of Therapeutic Communication

The technic of truth telling is something difficult, perhaps more difficult than the technic of lying,
but its results make it worth acquiring.

Richard Cabot

(7) Introduction

In this chapter I discuss the ethics of using doctor-patient communication in non-deceptive ways to modulate patient's health-outcomes through placebo and nocebo responses. Section (7.1) contextualizes the idea of relying on truthful verbal practices to harness the clinical effectiveness of placebo responses; section (7.2) defines the concept of "therapeutic communication" (or TC); section (7.3) provides a synthetic overview of the empirical evidence supporting the case for the effectiveness of TC; section (7.4) identifies in *veracity*, *helpfulness*, and *pragmatism* the three guiding coordinates for the ethics of TC; section (7.5) discusses two cases in which TC can be used to maximize placebo or minimize nocebo responses; section (7.6) analyses the possible application of TC to the case of open-label placebos.

(7.1) From autonomy to beneficence: why therapeutic communication

Compelling evidence from "open-hidden" experiments demonstrates that placebo responses may occur without the provision of a physical placebo (see 6.3). In this kind of experiments patients receive an effective medication (e.g. an analgesics) either by a clinician who explains the expected effects of the therapy (open administration), or through an automatic procedure such as an infusion machine (hidden administration) (Benedetti 2009). Both the open and the hidden groups receive the same amount of medication, and the only difference is the "informational context" surrounding its delivery. In general, open-hidden experiments demonstrate that, through placebo responses, the same dose of a drug may have different effects depending on other contextual variables such as the bedside presence of a nurse or the way in which it is verbally described (Pollo et al. 2001).

Since various components of the healing context may trigger significant placebo responses, it has been argued that physical placebos are unnecessary, as the same benefits can

be achieved in ways that are less controversial (Brody 1982; Miller and Brody 2011; Justman 2013). For example the AMA—in the same “opinion” on placebos mentioned in the previous chapter—observes, “Physicians can avoid using a placebo, yet produce a placebo-like effect through the skillful use of reassurance and encouragement. In this way, the physician builds respect and trust, promotes the patient-physician relationship, and improves health outcomes” (AMA 2006). The possibility of eliciting placebo responses without placebos hints at an intriguing series of new empirical and ethical challenges. There are at least three main reasons for which the possibility of using therapeutic communication deserves more attention.

First, even if one concedes that words alone are less powerful than physical treatments in eliciting placebo and nocebo effects, this does not mean that they are powerless. On the contrary, as I will show in section (7.3), we have good reasons to conclude that the power of therapeutic communication can sometimes be clinically significant.

Second, unlike the provision of physical treatments—and especially of placebic ones—the doctor-patient communication is ubiquitous in medical contexts. Physicians use words to formulate diagnoses and prognoses, to disclose the risks and benefits of medical interventions, and to explain why, how, and when a therapy will be administered to a patient. Likewise, patients communicate to describe their symptoms, to make sense of their conditions, to report side effects, to explore other therapeutic options, and to share their feelings. Thus, if clinicians’ words have a potential therapeutic effect, then harnessing such a power could be an important resource to improve patients’ care.

Third, so far the ethics of the doctor-patient communication has been typically conceived in the terms of a problematic balance between concerns of respect for patients’ autonomy and concerns of nonmaleficence. The typical case, discussed in the previous chapters, is that of an oncologist who must disclose some bad news to an emotionally vulnerable patient. What the new discoveries about the mechanisms of placebo effects bring

add to this debate is the idea that doctor's words may also have "placebo" as well as "nocebo-like" effects. Therefore, today doctor-patient communication can be interpreted not only as the primary means through which clinicians can respect patients' autonomy but also as an integral part itself of the therapeutic relationship.

(7.2) Defying "therapeutic communication"

Doctor-patient communication is a primary medium through which patients attribute meaning to their symptoms and adjust their expectations about what is yet to come. Communication by clinicians has the power to turn diagnoses and prognoses into parts of the treatment, to influence treatment effectiveness, and to modulate the way in which patients cope with their conditions (Benedetti 2011; Teutsch 2003; Fong and Longnecker 2010). Throughout this chapter, by "therapeutic communication" (TC), I mean any deliberate use by health professionals of forms of communication aimed at promoting placebo responses or inhibiting nocebo responses for the patient's medical benefit. Although this definition captures most of the cases discussed below, it requires some qualification.

First, the therapeutic effects of the patient-physician communication are not limited to promoting placebo (or avoiding nocebo) responses. For example, physicians may use words to motivate patients to adhere to a recommended treatment regimen, to choose a healthier lifestyle, to adopt better psychological attitudes, or to nudge their choices by framing information in different ways (Thaler and Sustein 2008; Miller and Colloca 2011). These forms of communication may (indirectly) contribute to patient benefit if they motivate patients to change their attitudes or behavior in ways that improve health (Street et al. 2009).

For the sake of clarity I propose to distinguish between direct and indirect effects of TC, and consequently between direct and indirect TC. TC is said to be direct whenever the act

of communication itself can be identified as the proximate and necessary cause of a measurable change in a patient's health outcomes. In most of the cases I assume that direct therapeutic communication acts through the modulation of placebo and nocebo responses. TC is said to be indirect whenever communication can be identified as a necessary but not as the proximate and sufficient cause of changes in patients' health-relevant outcomes.

A reassuring statement like "this medicine will make you feel better," leading to a short-term decrease in the patient's stress levels, qualifies as an instance of direct TC. On the other hand, structuring the doctor-patient communication to engage the patient in shared decision-making with the goal of enhancing treatment adherence, and thus improving some health outcomes, qualifies instead as an instance of indirect TC. On many occasions the same act of TC may elicit both direct and indirect effects. Furthermore, it is often difficult to distinguish between proximate and non-proximate causes. However, as I show below, there are cases in which it is clear that the patient-physician communication is the proximate and necessary cause of a change in a patient's health-related outcomes. Though both direct and indirect effects of TC deserve theoretical and ethical analysis, in this chapter I focus primarily on the former category, i.e., on those cases in which an act of TC elicits some effects on health-related outcomes through the modulation of placebo and nocebo responses.

Second, TC is not restricted to words but includes non-verbal ways in which physicians and patients communicate. These include gestures, visual cues, body language, attentive listening, thoughtful silence and other sensory stimuli. Among these other components of the clinical encounter some are of special importance and have been subjected to empirical studies. These studies reveal that besides words, variables such as the doctor's attitude (Thomas 1987), her perceived confidence (Uhlenhuth et al. 1966), the environment in which the healing takes place (de Craen et al. 2000; Thomas 1987), the ritual performed (Kaptchuk 2002), and the kind of medical instruments utilized (Waber et al. 2008; Johnson 1994). All of them may influence health outcomes (Walach 2011; Jonas 2011). However, in

this chapter I focus especially on the verbal and conscious components of direct TC rather than on the non-verbal and unconscious ones.

(7.3) The therapeutic power of communication

In the previous chapter we have synthetically reviewed the controversy about the clinical effectiveness of placebo treatments. In this section, instead, I should focus only on the available evidence concerning the power of verbal practices to shape health-relevant outcomes.

Physicians may use words as therapeutic agents in multiple ways. In the first place, physicians may employ direct TC while providing diagnoses. In one study, Thomas (1987) tested the effect of providing a firm diagnosis together with a positive and reassuring attitude with 200 patients who presented in his general practice with symptomatic complaints but no abnormal physical signs. Half of the patients received a “positive” consultation in which the physician communicated a firm diagnosis and confidently asserted that the patients would surely get better in a few days; the others half received a “negative consultation” in which the doctor told them “I cannot be certain what is the matter with you.” Two weeks after the consultation, a significant difference was found between those patients who received a positive consultation compared to those who received the negative consultation. Another study of 100 patients with acute tonsillitis led to analogous results, finding that “a deliberate attempt to maximize patients’ expectations through more detailed and positive diagnostic and prognostic information may influence the clinical course of acute tonsillitis, recorded as the degree of subjective improvement” (Olsson, Olsson, and Tibblin 1989).

Receiving a firm or an uncertain diagnosis affects also how people cope with unexplained symptoms, which alone account for at least 40% of physical symptoms presented

in outpatient clinics of gynecology, neurology and rheumatology (Reid et al. 2001). There are many conditions for which physicians lack an explanation for persisting medical symptoms, including chronic fatigue syndrome, irritable bowel syndrome, chronic pain syndrome, chronic pelvic pain, and pseudo non-epileptic seizures. Importantly, these are all conditions that are known to be amenable to placebo modulation (Bendetti 2009; Enck et al. 2013). A recent review article concluded that patients “report less symptoms ... when symptoms are properly explained” (Weiland et al. 2012). Similarly, providing a positive prognosis may shape patients’ expectations and have therapeutic effects. Egbert et al. (1964) found that patients who were informed and reassured about the course of their postoperative pain reported a reduction of it and requested significantly fewer analgesics compared to those assigned to the control group. A systematic review of the effects of “healing contexts” concluded that enhancing patients’ expectations through positive information and supportive reassurances “significantly influenced health outcomes” (di Blasi et al. 2001).

Engaging patients in shared medical decision-making is another way to modulate health outcomes and to enhance treatment effectiveness. For instance, letting people select between different pain coping strategies may enhance their pain-tolerance (Rokke and al’Absi 1992). Shared decision-making may have positive therapeutic effects because it enhances compliance with the therapeutic regime; it allows patients to match more efficiently their condition with available treatment options (Swift and Callahan 2009); alternatively, it may reinforce the patient’s sense of “personal control”—i.e., the “belief that positive and negative events are determined by and are dependent upon one’s own actions” (Geers et al. 2013, p. 550). A recent series of studies with healthy volunteers demonstrated that exercising choice over potential treatment alternatives for experimentally-induced pain enhances treatment outcomes, but only in those people who have a high desire of control, while it may be detrimental in people who are averse to taking control (Geers et al. 2013). This suggests that the very act of letting people exercise their preferences during therapeutic encounters may enhance therapy effectiveness.

Being unsure about whether or not one is receiving a real or a placebo therapy may influence its effectiveness. In a recent study by Kam-Hansen et al. (2014), 66 patients with recurring migraine headaches were randomized using a 2 x 3 balanced-placebo design. Half of the participants received Maxalt (10-mg rizatriptan), a proven drug for the relief of headache pain; half received instead an indistinguishable placebo pill. All participants received pills under one of the three information conditions: “Maxalt” (positive information), “Maxalt or Placebo” (neutral information), or “Placebo” (negative information). Hence, among those who received Maxalt some were induced to believe that they had received a placebo; and among those who received the placebo some were induced to believe that they had received Maxalt. The trial found that both the kind of pill received (Maxalt or Placebo), and the kind of information provided (“Maxalt”, “Maxalt or Placebo”, “Placebo”), significantly correlated with the final outcome. Pain relief was greater under positive information, medium under neutral information, and lower under negative information. Maxalt was more effective than placebo when both were correctly labelled. However, Maxalt mislabelled “placebo” was as effective as the placebo mislabelled “Maxalt.” Relative to no treatment, the placebo, under each information condition, accounted for more than 50% of the drug effect. Changing even a single word can lead to dramatic differences in the effectiveness of both established therapies and placebos.

Importantly, a physician’s words may also induce negative or nocebo effects. A study by Colloca, et al. (2008) showed that telling subjects that a painful stimulation will be delivered shortly results in an amplification of the pain (hyperalgesia) or in the perception of pain even when no painful stimulus is present (allodynia). In another study by Kaptchuk et al. (2006), participants with persistent arm pain were randomized to receive either acupuncture or a pill. However, all treatments were just placebos: the pill did not contain any active molecule with analgesic powers, and the acupuncture was “sham” in that it was performed with retractable needles. Yet, many patients reported side effects, some even discontinued participation in the trial. Those nocebo side effects matched the descriptions that were given in informed consent

documents. Similar effects were found by systematic reviews of anti-migraine trials, in which a high rate of side effects in the placebo control group matched those of real drugs (Amanzio et al. 2003).

In sum, clinician-patient communication can itself be directly therapeutic and utilized to shape how patients react to diagnosis, prognosis, and medical therapies, or to induce beneficial effects when a placebo is deceptively substituted for a real medication, or even when the placebo is described openly. Deliberate variations in language can also enhance or induce negative effects. In all these cases the common denominator is that the verbal context acts as a source of information that patients interpret as different forms of anticipatory cues about what is to be expected.

(7.4) The ethics of therapeutic communication

Doctor-patient communication may have significant therapeutic effects. In the case of direct TC, these effects occur through the modulation of placebo and nocebo responses triggered by psychological factors such as modifications of expectations, anxiety, or a sense of personal control. If this is correct, the way in which doctors influence patients' beliefs and attitudes may have direct consequences on therapeutic outcomes. This raises important ethical questions regarding whether it is legitimate for a physician to promote or remove a certain belief, or to present uncertain information in more affirmative terms, to take advantage of the power of direct TC. To what extent is it ethical to manipulate patients' expectations for the sake of promoting placebo and avoiding nocebo effects?

In this section I shall articulate the ethics of direct TC in terms of three morally relevant considerations: *helpfulness*, *veracity*, and *pragmatism*. Before beginning, however, two clarifications are in order. First, while the term "manipulation" may refer to an unscrupulous

way of exercising control over information with a misleading intent, it can also refer to a clever and skillful way of controlling information. According to the *Oxford English Dictionary*, to “manipulate” means primarily “to handle or control (a tool, mechanism, information, etc.) in a skillful manner”, and only then “to control or influence (a person or situation) cleverly or unscrupulously”. In its more general sense, “to manipulate information” is a morally neutral practice, as this manipulation can lead to good or bad outcomes and be inspired by good or bad intentions; in its more restricted sense, instead, manipulation means to control information with the intention to mislead. It is important to keep distinct these two senses in which manipulation can be understood because several ethical quandaries surrounding the use of TC stem from a failure to recognize that a deliberate act of information manipulation is not necessarily misleading.

Secondly, TC always takes place within a therapeutic encounter involving an asymmetrical relationship between, on the one hand, a professional clinician with medical knowledge, skills and the social authority accorded to this role and, on the other hand, a vulnerable patient in need of help (see 3.1). As a consequence, patients necessarily have to rely on trust in their clinician (Pellegrino, Veatch, and Langan 1981). As defined in the previous chapters, here by “trust” I shall mean the attitude that someone (the trustor) has toward someone else (the trustee) and that entails both an expectation as well as a positive attitude toward the trustee’s technical competencies and moral disposition (see *infra* 3.1.b). On the traditional beneficence-inspired model, communication within this asymmetrical relationship was generally governed by the capacities of the doctor to help the patient with her suffering. Today, however, TC ought to reflect also physician’s commitment to honesty. Patients need to trust that their physicians can guide them toward better health without compromising the truthfulness that grounds every doctor-patient relationship.

In light of these remarks, I propose to conceptualize the role of the physician using TC as that of a *trustworthy guide* able to combine *helpfulness* and *veracity*. By *helpfulness* I mean that

physicians should be committed to use their knowledge to alleviate the patient's suffering and/or to promote her health and wellbeing. But even when no cure or effective treatment is available, a clinician may still be of help by providing compassion, empathy, and a caring attitude. In this respect, "helpfulness" is thus a shorthand term for the clinicians' *prima facie* duties of beneficence and non-maleficence. By *veracity*, instead, I mean the physician's commitment to provide patients with truthful information about their diagnosis, prognosis, and proposed interventions, without manipulating their beliefs in misleading ways, consistent with the principle of respect for patient's autonomy and their other obligations as medical professionals, especially those of fidelity and truthfulness (Beauchamp and Childress 2009). Hence, "veracity" is simply a shorter form to indicate the clinician's *prima facie* duty of veracity.

By characterizing the role of the physician engaging in TC as that of a trustworthy guide who must combine *helpfulness* and *veracity* it becomes possible to distinguish several general cases. The simplest scenario occurs whenever direct TC is clearly unhelpful. Like any other medical intervention, direct TC has an instrumental value and is directed at promoting the patient's health. But since direct TC operates through the modulation of placebo and nocebo responses, its *helpfulness* is limited only to those health outcomes susceptible of placebo modulation. So far there is no evidence that placebo responses may contribute to the shrinking of tumors, and consequently direct TC is unhelpful for cancer. (But it could still be used to manage symptoms and side effects of anti-cancer therapies). However, direct TC aimed at promoting unrealistic beliefs and expectations may interfere with the provision of care (for example by delaying the use of effective therapies), hence exposing patients to severe harm. Thus, whenever direct TC is unhelpful it is either futile or unethical.

A different situation obtains when direct TC can be helpful but at the cost of *veracity*. Consider the case of a clinician who administers a deceptive placebo by stating: "This injection of morphine will reduce your pain". Here the clinician manipulates a patient's expectations in order to induce a positive placebo response; hence this statement is an

instance of direct TC. Since the clinician is stating a lie intended to benefit the patient this act of direct TC is paternalistic. The question of whether this act of direct TC is morally permissible is thus the question of whether paternalistic deception is justifiable in these particular circumstances. Accordingly, moral dilemmas that involve the use of direct TC and a possible violation of the clinicians' *prima facie* duty of veracity ought to be interpreted and resolved according to the perspective that I have elaborated and defended in the previous chapters.

On other occasions, however, the moral issues raised by direct TC are not those related to a violation of the clinician's *prima facie* duty of veracity. In fact, sometimes an act of direct TC may be both truthful and helpful, but it may be *prima facie* unclear how *veracity* and *helpfulness* have to be balanced in those specific circumstances. Since these cases constitute the distinctive problematic core of the ethics of TC, let us briefly characterize them. First, consider the case in which a clinician is disclosing to a patient the side effects of treatment "T"; "T" has both significant side effects that are not prone to placebo modulation (e.g., an increased risk of glaucoma) as well as other nonspecific side effects (e.g., anxiety and drowsiness). If the clinician describes these nonspecific side effects, then she will increase the likelihood that such effects will occur due to expectation-based nocebo responses (Cohen 2012; Colloca and Finniss 2012; Wells and Kaptchuk 2012; Miller and Colloca 2011). Accordingly, the clinician is unsure about whether she ought to label those nonspecific side effects (e.g., "T may cause anxiety and drowsiness"), or vaguely refer to them using a general phrase (e.g., "If you feel something new or unusual after taking T, please call me"). The first formulation is more accurate than the second, but also more likely to induce the described side effects through nocebo responses. In this case it is *prima facie* unclear which of the two possible formulations provides the optimal balance between *veracity* and *helpfulness*.

Second, consider a clinician who, instead, decides to describe the nonspecific side effects of "T" but is unsure about whether to say that "T may *sometimes* cause effect y" or that

“T may *rarely* cause effects y”. Based on her knowledge and available evidence, she concludes that the first formulation is slightly more accurate than the second but also more likely to induce self-fulfilling nocebo side effects. In this case, it is again *prima facie* unclear which formulation entails the optimal balance between *helpfulness* and *veracity*: since they are both helpful and truthful to different degrees, it is an open question whether they are equivalent or whether one is better than the other.

These problematic cases arise because, as we have seen, clinician’s commitment to *veracity* is always context-dependent and audience-sensitive (Manson and O’Neill 2007; Wells and Kaptchuk 2012; see 2.2). Clinicians are under the obligation of truthfully informing patients about their diagnosis, prognosis, available therapeutic options, and the possible effects of prescribed interventions. But the specific content and forms of clinical truth telling depend on the clinician’s personality, culture, and communicative skills and may vary in different contexts so as to match a patient’s features, responses and needs. Since each therapeutic encounter is a unique event, in each case the final decision about which items of information are relevant and how they should be communicated is left to the clinician’s judgment.

Although a commitment to *veracity* may partially determine which information ought to be disclosed (e.g., which intervention will be performed), clinicians have a substantial degree of discretion in deciding what will be said on each occasion. Physicians’ leeway in crafting information disclosure is particularly relevant for direct TC, where even a single word (e.g., “placebo” instead of “Maxalt”) may lead to significantly different clinical outcomes. Given the multitude of possible alternatives that characterize the crafting of each information disclosure, clinicians engaging in direct TC can expect to face many cases in which it is at least *prima facie* unclear how they should balance *veracity* and *helpfulness*.

How should physicians approach these controversial cases? My proposal is that clinicians engaging in direct TC may rely on a third moral coordinate, *pragmatism*, to determine the optimal balance of *helpfulness* and *veracity*. Unlike *helpfulness* and *veracity*, *pragmatism* is not a substantive moral value, but is rather a procedural principle useful to guide clinicians in deciding between different ways of disclosing information. *Pragmatism* can be expressed in the form of a general maxim of conduct stating: “Between two acts of direct TC that involve balancing helpfulness and truthfulness, choose the one that is anticipated to have the most favorable practical consequences”. In this form, *pragmatism* amounts to a general consequentialist precept that invites clinicians to ascertain what practical differences it would make to choose a verbal formulation over another one when attempting to balance helpfulness and truthfulness. Applying this general maxim, I argue, may facilitate clinicians’ decision-making by indicating how to interpret and resolve moral dilemmas about controversial cases involving non-paternalistic acts of direct TC.

Taking a pragmatic perspective entails two main procedural steps. The first step consists in clarifying the moral dilemma beneath each controversial case by reformulating it as a choice between two alternative verbal disclosures. For example, if a clinician is unsure about whether she should label the nonspecific side effects (“x, y, and z”) of a prescribed treatment (“T”), according to *pragmatism* the first step to take is to rephrase this moral dilemma in terms of two alternative information disclosures: one in which those side effects are labeled (e.g., “T may have effects x, y, and z. Call me if you experience any of them”) and one in which they are not (e.g., “Call me if you experience any new or unusual effect after taking T”). At this level, adopting a pragmatic perspective entails that any question or doubt about whether an act of direct TC provides an optimal balance between *veracity* and *helpfulness* can be expressed in terms of two alternative ways in which a specific piece of information could be added, omitted, rephrased, or framed.

The second step, then, consists in determining which formulation provides the best balance between *helpfulness* and *veracity* by looking at their respective practical consequences. Given the characterization of direct TC that we have provided, there are at least two series of consequences that are of relevance in evaluating each act of direct TC: one concerning the specific health outcomes targeted by the act of TC; and the other concerning the individual patient to whom the act of direct TC is addressed. I shall now explain how the consideration of these two aspects may aid clinicians in approaching controversial cases involving direct TC in clinical settings.

(7.5) Using therapeutic communication in clinical contexts: two examples

In this section we shall apply the considerations of *helpfulness*, *veracity*, and *pragmatism* to analyze two cases in which direct TC is used to enhance the effectiveness of (a) proven medications and of (b) open-label placebos.

(7.5.a) Using direct therapeutic communication with proven medications

As open/hidden studies show, informing patients that they are about to receive a medication that will relieve their pain may be responsible for a substantial proportion of the pain relief actually experienced by the patient. This suggests that direct TC can be used to enhance the overall effectiveness of standard analgesics by openly reinforcing patients' expectations during their administration. While several commentators have hinted at this possibility (Brody 1992; Miller and Colloca 2011; Justman 2013), to my knowledge a detailed discussion of the ethics of manipulating verbal information for the sake of enhancing the effectiveness of prescribed medications is yet to be provided. In this respect, applying the theoretical framework

elaborated in the previous sections may provide a preliminary charting of the practical and moral issues pertaining to these common scenarios.

Consider the case in which a hospital clinician is about to administer an analgesic to a patient in postoperative settings with the purpose of meeting the requirements of informed consent. Let us suppose that, in this case, the busy clinician states: (a) “This pill is a painkiller containing morphine”. Now consider the same situation from the perspective of a clinician using direct TC. (For simplicity, we shall assume that the drug has no relevant side effects). Clearly, this time the clinician would face a different question, as the goal of her disclosure will be to maximize the potential therapeutic effects of the analgesic drug (*helpfulness*) without compromising—and possibly fostering—patient’s autonomy and the mutual trust grounding the therapeutic relationship (*veracity*). After pondering various alternatives, she concludes that a viable information disclosure could be: (b) “We want to minimize your pain after surgery by giving you this pill called X. X contains morphine. Morphine is a very powerful painkiller. Thus, you can expect your pain to be relieved soon. Please let me know if you continue to feel pain”. Neither (a) nor (b) are misleading ways of disclosing information about the provided medication. Given the prior analysis of direct TC, however, we argue that the second formulation has the potential to enhance patient outcomes with minimal communicative burden on clinicians. If this is correct, then adopting TC has important implications for the way in which clinician-patient communication is currently conceived, regulated by ethical guidelines, and taught in professional schools.

To sustain and unpack this claim, let me briefly compare (a) and (b) by looking at their practical consequences. First, we shall compare the two disclosures as for their likely effects on the health outcome considered, in this case postoperative pain. Since this is a condition known to be highly susceptible to placebo modulation, both formulations may reasonably be expected to reinforce a patient’s positive expectations, hence leading to an enhanced overall analgesic response which is likely to be a function both of the pain-relieving properties of the

medication and the psychological benefits of positive expectations. However, the two formulations are not identical: (b) is more specific than (a) and provides the patient with additional cues about the reason for the administered treatment, its known efficacy (“very powerful painkiller”), the effect to be anticipated (“pain relief”), an approximate timing (“soon”), and invites the patient to seek additional help if the relief is not adequate. According to the empirical evidence reviewed in section (7.3), (b) has an increased likelihood of inducing more robust placebo responses than more generic formulations like (a).

Furthermore, while (a) is *accidentally* helpful (b) is *deliberately* calculated to maximize patient’s expectations of a clinical improvement. The difference between accidental and deliberate *helpfulness* becomes obvious as we compare the two disclosures over time. Patients in postoperative settings are likely to need more than one administration of analgesics, as pain management may range from hours to years. The ritual of clinical truth telling entailed by the use of direct TC can be iterated—with due variations—so as to enhance clinical outcomes on multiple occasions. Even if in each case placebo-induced responses contribute only marginally to the final therapeutic outcome, in the long run their aggregate effect might become very significant. By contrast, the accidental *helpfulness* of the first formulation is likely to diminish over time, as clinicians have no incentive in repeating the act of information disclosure once the requirements of informed consent has been already met (for example, they may resort to even more generic formulations, like “it is time to take your medicines”). Thus, direct TC may retain a clinical utility even when its function for the purpose of informed consent has been already met.

Provided that clinicians remain committed to *veracity*, there is no reason to see this use of direct TC as deceptive in view of what we know both about the pain-relieving properties of analgesic agents and the effects of expectations on pain relief. There is nothing misleading about aiming to promote positive expectations, insofar as scientific evidence and clinical experience supports the potential for expectation-induced benefit in the condition presented

by the patient. As long as the practice of telling the truth can bring about beneficial effects on a patient's relevant outcomes without compromising her individual autonomy or the bond of trust, I contend that clinician's use of direct TC is an ethical way of optimizing the effect of therapeutic outcomes. Therefore, given their potential therapeutic benefits and minimal burden on clinicians, I argue that clinicians should systematically adopt adjuvant techniques of direct TC whenever they administer analgesics in clinical settings.

Using the same argument sketched above, the case for implementing adjuvant techniques of direct TC can be generalized to other similar scenarios. In particular, I maintain that the adjuvant use of direct TC is generally ethical whenever it:

- i. Does not involve misleading communication;
- ii. Targets a health outcome prone to placebo modulation;
- iii. To the extent feasible, takes into account the patient's unique clinical profile and agency;
- iv. Has negligible risks for patients' health and wellbeing;
- v. Has negligible costs.

Whenever these five conditions obtain, clinicians should consider the use of adjuvant techniques of direct TC while administering proven therapies to optimize patient care.

Aside from pain-management, another likely area for implementing the systematic use of adjuvant techniques of TC is in the treatment of patients with depression. Placebo-controlled trials suggest that most of the benefit that depressed patients receive from taking antidepressant medication is matched by those who receive masked placebo treatments (Benedetti 2011; Kelley et al. 2012). Assuming that pharmacological intervention for depression is judged as the best therapeutic option for an individual patient, we maintain that in discussing this medical intervention it will be ethical for the clinician to openly reinforce the positive expectations of the patient about its effectiveness—e.g. by saying: “This medicine is “X”. It has been proven that “X” is effective in clinical trials. Hence, I expect you to improve

while taking this medicine and experience a reduction of your depressive states”. If a pharmacological intervention is already the selected course of action for the treatment of a condition which is highly prone to placebo modulation, there is no reason not to enhance its possible beneficial effects if these results can be ethically achieved without resorting to lies or deception and in a way that is cost-effective and without additional risks for a patient’s health.

(7.5.b) Using direct therapeutic communication with open-label placebos

The use of adjuvant techniques of direct TC becomes controversial when it is directed at enhancing the effectiveness not of proven medications but of open-label placebos (OLPs). By definition, a placebo treatment lacks inherent therapeutic properties: it has no ingredients or components with the physical properties of producing beneficial health outcomes. Should clinicians use techniques of direct TC to enhance (or confer) clinical effectiveness to OLPs?

Before answering this question it is important to make an important distinction concerning the underlying mechanisms through which OLPs are supposed to operate. So far, we have explored the ethics of direct TC on the assumption that the primary mechanism of its action is the modulation of patient’s expectations and beliefs. However, as discussed in (6.3), once a physical treatment is prescribed along with a verbal description it can also be the case that other placebo mechanisms may be recruited and that the final therapeutic outcome is a function of their overall therapeutic effect.

With respect to the use of OLPs, for example, it has been suggested that they can be effectively incorporated as part of a therapeutic regime based on deliberate pharmacocconditioning. In these therapeutic protocols an OLP is paired with an active medication until the administration of the OLP alone induces a conditioned placebo response that mimics the

effects of the medication. Evidence from pilot studies in psoriasis (Krueger 2006) and ADHD (Sandler 2008) suggests that OLPs based on pharmaco-conditioning may be effective in maintaining therapeutic responses while reducing the side effects of active medications. If further studies confirm these findings, then OLPs used in therapeutic regimes based on pharmaco-conditioning might represent the least controversial way of incorporating placebos in real clinical settings. However, even in these cases in which the primary target mechanism is classical conditioning, researchers and clinicians have still to *describe* the OLPs hence providing a way of maximizing their effectiveness. Therefore, also in these cases it is relevant to analyse how adjuvant techniques of direct TC can be ethically deployed.

Let us begin by considering the trial, mentioned in section (7.3), which investigated whether there could be a “placebo without deception” in patients with IBS (Kaptchuk et al. 2010). As part of the disclosure procedure, the participants in this study were presented with the following script: “placebo pills, something like sugar pills, have been shown in rigorous clinical testing to produce significant mind-body self-healing processes” (Kaptchuk et al. 2010, 2). This script was meant to enhance positive expectations in order to measure whether the placing of hope and trust in a treatment known to be a placebo might still have therapeutic value; it was therefore an act of direct TC. But was it sufficiently truthful? In a critical commentary Justman (2013, 328) contends that the answer is negative because this script is

[a] variant of the sale pitch that has been employed in open or semi-open or indeed deceptive placebo experiments (...) The impressive rhetoric of “rigorous clinical testing” in the study’s script makes placebo sound like a medication in its own right, or at least like something of attested efficacy (...) What of the benefits attributed to the placebo treatment? While placebo produces reports of improvement in countless clinical trials (...) the claim that such improvement represents the work of “significant mind-body self-healing processes” is arguably both tendentious and inflated. Despite the inspirational rhetoric of “healing,” the only sense in which the study subjects treated with open placebo were healed is that many of them felt better. Their IBS itself did not heal in the way ulcers, for example, do – with or without treatment. According to the OED, the first meaning of “to heal” is “to make whole or sound in bodily condition; to free from disease or ailment, restore to health or soundness; to cure.” Placebo treatments of IBS do none of this.

By making use of “half-truths” and “inflated rhetoric”, the script in the IBS study, according to Justman, portrayed OLPs as if they were known to be “effective” and “capable of “healing”. However, these claims are not self-evident. First, while it is true that double-blind administration of placebos has led to clinical improvements in rigorous testing, those trials did not employ OLPs for IBS. Hence it is questionable whether the script was sufficiently transparent as to the effectiveness of OLPs. Second, it is also questionable to what extent OLPs could contribute to healing given that they are just placebos with presumably no effects on pathophysiology. Therefore, Justman argues, the IBS trial script was not transparent and did not avoid deception. This conclusion, however, is dubious. While it is true that many disclosures in placebo research are deceptive and thus ethically problematic (Miller et al. 2005; Miller and Kaptchuk 2008), this may not be the case of the script of the IBS study—nor of other studies investigating the efficacy of OLPs.

For one thing, Justman is right in noting that the disclosure procedure reported in the published IBS article did not make explicit whether the participants were informed that OLPs were unproven interventions. Since that trial was about “placebo without deception”, a failure to explain in details how the information disclosure took place during the study should be considered a shortcoming of the published article.

Yet, from the fact that the script reported in the paper did not report that information, it does not follow that the participants in the IBS trial were lead to believe that OLPs were known to be effective for IBS. In fact, as it can be ascertained by the documentation submitted to the Institutional Review Board for this trial, researchers did clearly point out that OLPs were then unproven interventions for IBS (Kaptchuk 2014, personal communication). Accordingly, the provision of OLPs in that trial (and by extension their possible use in clinical scenarios) was not deceptive or lacking transparency in this respect.

Furthermore, Justman's second remark about the exaggerated benefit of OLP is problematic. The IBS trial found that 59 percent of patients who received the placebo reported adequate relief as opposed to 35 percent of those in the "no-treatment" control group. (Adequate relief was assessed through the same criteria used by the FDA to approve pharmacological interventions for IBS). Thus, for 24 percent of the participants, the OLP *did* make a significant clinical difference compared with no treatment. Are these improvements to be considered as signs of "healing"?

In the case of symptomatic conditions like IBS—where health-related outcomes like stress, relaxation, and quality of life are directly linked to the physical symptoms defining the condition—we contend that the answer is "Yes". Not everything that falls within the domain of medicine and medical expertise "heals" like "ulcers do". "Healing" is a capacious term, which includes symptomatic relief as well as cures. Psychotherapy, pain-management, anxiety and sleep disorders, hypertension, some sexual dysfunctions, etc. are just a few examples of therapies and conditions for which a purely pathophysiological approach to diagnosis and therapy may prove to be insufficient. Therefore the interpretation of "healing" assumed by Justman is just too narrow to account for many medically relevant phenomena, including placebo effects.

Justman's critique has thus the merit of underscoring how subtle the boundary between truthfulness, manipulation, and deception can be—especially when direct TC is used in conjunction with a placebo (whether OLP or not). However, from this recognition it does not follow that every instance of direct TC aimed at administering an OLP is necessarily untruthful. For example, in scenarios similar to the one of the IBS trial, we suggest that clinicians may describe OLPs in the following truthful way:

"This pill is a placebo; as such, it does not contain any pharmacologically active ingredient. It is something like a sugar pill. However, rigorous clinical testing has shown that even this kind of intervention may have clinically relevant effects by inducing what is called a "placebo response". Placebo responses are part of the way in which our body and

mind reacts to the provision of care and to salient features of the therapeutic context. Thus, if you regularly take these pills, you may experience some improvement in your condition”.

This script is meant to promote positive expectations about the effectiveness of OLPs without compromising *veracity*. Provided that the OLP does not replace a more effective treatment and that the patient may autonomously choose among different treatment options, if the efficacy of OLPs is backed up by experimental evidence (i.e., it is helpful), and if the nature of the intervention—e.g., a pill without any medication in it—is clearly made explicit (i.e., it is truthful), then it can be ethical to administer this kind of intervention accompanied by reasonable communication of positive expectation.

(7) Summary

In this chapter I have discussed the ethics of using forms of therapeutic communication to modulate patients’ health-outcome through placebo and nocebo effects. I have thus characterized the role of the clinician engaging in direct TC as that of a trustworthy guide able to combine *veracity* and *helpfulness* in the light of *pragmatism*. In particular, I have argued that *pragmatism* can be used to clarify and resolve controversial cases in which it is *prima facie* unclear how to balance *veracity* and *helpfulness* in specific circumstances.

Using this theoretical framework I have analysed the ethics of using techniques of direct TC to enhance the effectiveness of proven medications and OPLs by fostering patients’ positive expectations. I have thus contended that clinicians should consider the systematic adoption of adjuvant techniques of direct TC to enhance the overall effectiveness of prescribed medications (and also of OPLs—provided other conditions are met). Embracing this proposal would result in a cost-effective and low-risk way of providing superior care to

patients who are already taking medications for highly prevalent conditions such as pain, depression, anxiety, insomnia, irritable bowel syndrome, and recurring migraine.

Implementing direct TC in clinical settings, however, calls both for more empirical research and for a global reconsideration of the way in which doctor-patient communication is currently practiced in clinical settings. Moreover, clinicians should start to reconsider the way in which they communicate with patients as one of the primary means at their disposal for modulating patients' overall therapeutic experience in significant ways.

Conclusions.

There's one way to find out if a man is honest—ask him. If he says “yes”, he is a crook.

Groucho Marx

Doctor-patient communication is key to clinical medicine. Clinicians' words may modulate health-outcomes through placebo and nocebo responses, communicate diagnostic and prognostic information, aid patients with difficult decisions, or preserving hope and autonomy in the most desperate of the situations. In any case, clinicians' words have the power to transform the lives of those to whom they are addressed in significant and irreversible ways.

In exchange for this power, clinicians are entrusted by society with a series of moral responsibilities and duties disciplining, among other things, also the veracity of their professional communications. In order to protect patients from harm and exploitation as well as to be able to deliver the best quality of care, today it is assumed that clinicians have a duty of telling the truth to their patients. Abiding to this duty, however, entails two difficulties. First, sometimes it is clear that a clinician should tell the truth to patients, but doing so can be very difficult. Veracity and honesty can sometimes be painful for those who have the right to know as well as for those who have the duty to inform.

Other times, instead, it is not clear what a duty of veracity entails. Should a clinician tell the truth to a vulnerable patient? Is it justifiable for a doctor to lie about the suffering of a beloved one out of compassion? Among the different ways in which the truth about medical relevant information can be disclosed, which one is to be preferred for its likely impact on patient's health and well being? In this dissertation I focused my attention mostly on this latter kind of problems concerning the ethics of truth-telling in clinical and oncological settings, suggesting that the first approach that we ought to endorse is one for which there is no a-priori categorical answer to any of the above questions. Medicine is not an exact science; rather, it is a pragmatic activity in which different individuals who may hold diverse values and beliefs must often decide between competing alternatives while having inadequate knowledge.

To cope with these difficulties, I have suggested that a promising way of conceptualizing clinicians' duty of truth telling is by adopting the Rossian distinction between

prima facie and actual duties. *Prima facie* duties correspond to moral obligations that ought to be considered binding unless one has compelling reasons to do otherwise. In medicine, these other compelling reasons are likely to refer to other *prima facie* obligations to which clinicians are expected to abide. Thus, other things being equal, clinicians must tell the truth to their patient. However, sometimes things are not equal, as sometimes *prima facie* obligations may legitimate conflict. Whenever a conflict of this kind occurs, we have to identify and weight the reasons supporting one obligation against those supporting the other, thus determining which one should override the other and be our actual duty in these circumstances. Actual duties are those *prima facie* obligations that we have to respect after all things have been considered.

The view that clinicians have a *prima facie* duty of veracity is *per se* not controversial in today medical ethics. However, in difference to the vast majority of other accounts endorsing this view, throughout this dissertation I have defended two original claims. First, I have maintained that the negative presumption against violating clinicians' duty of veracity should be regarded as being very strict: it is morally permissible to violate this duty only in exceptional cases. These exceptions are even sparser, I have suggested, in the case in which the deceptive act entails the use of a physical intervention such as a pure or an impure placebo.

The other distinctive feature of my view is the idea that other accounts conceptualizing clinicians' duty of veracity as a *prima facie* duty are, in absence of further qualifications, likely to lead clinicians to take suboptimal moral decisions because of three reasons. First, the extension of the *prima facie* duty of veracity may be unclear at the outset. Although we are all to some extent familiar with lying, deception, concealment and the telling of half-truths, these concepts require some theoretical work before they can be clarified as to determine how someone may not respect an obligation of veracity. Drawing on the existing literature, I have distinguished these concepts, proposing to conceptualize clinicians' *prima facie* duty of veracity as the conjunction of two other *prima facie* obligations: the negative obligation to refrain from lying and deceiving (i.e., the "duty of truthfulness"), and the positive obligation

to provide patients with all the relevant information needed to respect their autonomy (i.e., “the duty to inform”).

A second reason for which other accounts may not be satisfactory resides in their under-theorization of the morality of using deception in clinical communications. For one thing, those who deceive are generally prone to deceive even more, and this is both because duplicity may contribute to “corrupt” our moral character, and because it might require the deceiver to use more lies in order to shore up those that have already been said. While we tend to conceptualize the morality of lying and deception by focusing on single episodes, they rarely occur as such: concealment and deception may easily “spill over” into a lie and dishonesty may always have long-term consequences. For another thing, instead, lying, deceiving and concealment do not have intrinsically different moral weights, as it is sometimes mistakenly claimed, but their moral status is always context and audience dependent. Lies are usually more culpable than evasive answers, but this is not a given in all circumstances.

More importantly, other accounts do not take into adequate consideration the discrepancy of the perspectives, which may lead the deceiver and the deceived to appraise in two very different ways—each one biased and limited—the moral implications of the same deceptive act. Like a court of law in which only the reasons of the indicted or those of the victim are weighed in the final verdict, without controlling for the biases introduced by the discrepancy of the perspectives, the final moral judgment over the moral permissibility of a deceptive act is likely to be skewed in one sense or the other. This aspect is particularly relevant in clinical contexts for two complementary reasons. First, because there exists a power asymmetry between physicians and patients, with the latter depending on help and knowledge of the former to recover their health. Second, because clinicians are often in the best possible position to profit by the free-rider status of being the deceivers, as they can propose, evaluate, and enact deceptive acts in full secrecy.

In light of these considerations, I have argued that other accounts fail to provide a satisfactory normative theory for thinking about the ethics of truth-telling and benevolent deception in clinical contexts. On the one hand, perspectives like Beauchamp and Childress's one are inadequate because they overemphasize the respect of patient's autonomy over the preservation of the bond of trust and ignore the biases potentially introduced by the discrepancy of the perspectives. On the other hand, categorical positions equally fail because they provide a suboptimal trade-off between their ability to enforce a strict ban on dishonesty and the undesirable and counterintuitive consequences that follow from such a ban.

To overcome these limitations, I have proposed a normative solution based on the concept of publicity. Building and extending upon Bok's original proposal, I have thus elaborated and defended a procedural theory for justifying benevolent deception in clinical contexts based on three passages—which have been phrased as three tests that clinicians ought to take before reaching the conclusion that an act of deception may be morally permissible. These are the test of “veracity”, “publicity”, and “public disclosure”. A proposal to resort to deception would pass these three “moral safety-checks” if and only if those supporting it would: be able to argue that there are no other truthful and plausible ways of achieving the desired end; be ready to defend their reasons in front of a public jury composed of their peers, other reasonable persons and those who share the perspective of the deceived; select the best techniques of actual publicity to publicly disclose, either prospectively or retrospectively, that an exception to the duty of veracity was or will be made. Whenever these three conditions are met, I argued, resorting to benevolent deception might be morally permissible.

The view that I have proposed has several advantages, as it allows clinicians evaluating the moral permissibility of clinical deception to: (a) refine and correct their argumentations; (b) reduce the fallibility of their moral judgments; (c) achieve less biased conclusions about what their actual duties should be in each particular case; (d) reinforce patient's and society trust in clinicians' professional trustworthiness; (e) facilitate internal and public discussion on how

doctors can best cope and be prepared to face certain scenarios. This view, however, has also some limits, such as the one of being potentially quite demanding in terms of time and cognitive resources, and thus of being applicable only in those cases in which a deception is planned rather than in those cases that require a quick decision. To reduce this drawback, I have adapted and modified a decisional flowchart first proposed by Sokol (2007) to aid clinicians in taking better real-decisions on moral dilemmas about truth telling.

Equipped with this general normative theory, in the second part I have explored the recent debate prompted by new empirical discoveries over the mechanisms of placebo responses. Compelling empirical evidence demonstrates that, inasmuch as different variables of healing contexts may serve as anticipatory cues of future clinical improvements, inert placebos—or even just the doctor’s words—may contribute in shaping a plethora of patient’s relevant outcomes through the promotion or inhibition of placebo and nocebo responses.

I have then analyzed both the current debate over the moral permissibility of administering deceptive placebos in clinical contexts, as well as the newer strands of the placebo debate, which deal with the moral implications of administering placebo without deception, or with the ethics of promoting and inhibiting placebo and nocebo responses without administering any physical treatment. I have thus argued that my perspective provides a superior theoretical starting point to think about the moral implications of administering deceptive placebos in clinical contexts, as it is able to distinguish those very few exceptional cases in which this practice is desirable and morally permissible given its potential therapeutic and diagnostic value, from all other cases, which represent by far the greatest majority, in which the use of deceptive placebos should instead be considered unethical.

Finally, I have inquired into the relatively unexplored issue of how clinicians should decide between different truthful statements if their aim is that of maximizing placebo responses (or minimizing nocebo ones) without resorting to paternalistic deception. After

having introduced and defined the concept of “direct therapeutic communication”, I have then provided a first analysis of the ethics of therapeutic communication based on the three moral coordinates of *veracity*, *helpfulness* and *pragmatism*. The view that I have defended is that clinicians and oncologists should already strategically implement within their daily practices techniques of direct therapeutic communication with the adjuvant function of maximizing the overall effectiveness of proven medications—especially analgesics. This would allow clinicians to capitalize on the therapeutic power of placebo responses in a way that is not deceptive, low-risk, and highly cost-effective, hence providing patients with a superior quality of care.

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