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A Limited Defense of Clinical Placebo Deception

Adam Kolber

Brooklyn Law School, adam.kolber@brooklaw.edu

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YALE LAW & POLICY REVIEW

A Limited Defense of Clinical Placebo Deception

*Adam J. Kolber**

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* Associate Professor of Law, University of San Diego and Laurance S. Rockefeller Visiting Fellow, Princeton University, Center for Human Values. For helpful comments, I thank Paul Arnstein, Sissela Bok, Kathleen Boozang, Howard Brody, Michael Brooks, James DuBois, Bennett Foddy, Barbara Gilchrist, Laura Hermer, Ivy Lapidés, Jerry Menikoff, Dina Mishra, Patrick S. O’Donnell, Jane Ong, Sarah Pinkerton, Ben Rich, Maimon Schwarzschild, and Matt Zwolinski. I also thank participants at Saint Louis University’s 2006 Health Law Scholars Workshop, the 2007 annual conference of the Society for Evolutionary Analysis in Law, and a University of San Diego School of Law faculty colloquium. This project was generously supported by a summer research grant from the University of San Diego School of Law.

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INTRODUCTION

Placebo treatments, like sugar pills and saline injections, are effective in treating pain and perhaps a host of other conditions. In fact, recent neuroimaging studies show that the pathways of placebo pain relief in the brain largely overlap the pathways of pain relief from drugs like morphine.¹ Placebos are also cheaper and safer than corresponding active medications. To most effectively use placebos to diagnose and treat patients in clinical practice, however, doctors must deceive patients as to the placebo nature of the intervention. Such deception runs counter to a fifty-year trend in medical ethics and health law that emphasizes patient autonomy and requires doctors to disclose the nature of a proposed intervention in order to obtain patients' informed consent.

The legality of deceptive placebo use has long been murky.² This changed to some extent in November 2006 when the American Medical Association (AMA), the most powerful and influential organization of doctors in the United States, adopted an ethics policy prohibiting the deceptive

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1. See, e.g., WALTER GLANNON, *BIOETHICS AND THE BRAIN* 92-103 (2007); Ginger A. Hoffman et al., *Pain and the Placebo: What We Have Learned*, 48 *PERSP. BIOLOGY & MED.* 248, 260-62 (2005); Predrag Petrovic et al., *Placebo and Opioid Analgesia—Imaging a Shared Neuronal Network*, 295 *SCI.* 1737 (2002); Tor D. Wager, *The Neural Bases of Placebo Effects in Anticipation and Pain*, 3 *SEMINARS PAIN MED.* 22 (2005); Tor D. Wager et al., *Placebo-Induced Changes in fMRI in the Anticipation and Experience of Pain*, 303 *SCI.* 1162 (2004).
 2. See *infra* Sections II.B-E.

use of placebos.³ Because courts are likely to be influenced by the AMA Code of Medical Ethics when evaluating norms of professional conduct,⁴ it is now more likely than ever that doctors who deceptively administer placebos can be held liable for failing to obtain patient informed consent.⁵ They also risk professional discipline,⁶ as well as civil or criminal liability under

3. At a June 2006 meeting, the AMA's House of Delegates (the organization's policy-setting body) considered a proposal to prohibit placebo deception put forward by the AMA's Council on Ethical and Judicial Affairs (CEJA). In response, members of the House of Delegates made "lengthy vocal protests, demanding that [CEJA] reconsider its" proposal. Peggy Peck, *AMA: Ethics Council's Stance on Placebo Therapy Stirs Unease*, MEDPAGE TODAY, June 16, 2006, <http://www.medpagetoday.com/PublicHealthPolicy/HealthPolicy/tb2/3555>.

In November 2006, however, the House of Delegates adopted CEJA's revised proposal, even though its wording differed only slightly from the June 2006 version. See Council on Ethical & Judicial Affairs, Am. Med. Ass'n, Report 2-I-06, *Placebo Use in Clinical Practice (2006)* [hereinafter *AMA Recommendations*] ("Physicians may use [a] placebo[] for diagnosis or treatment only if the patient is informed of and agrees to its use."), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_2i06.pdf.

CEJA also wrote a report supporting its recommendation that has not yet been published. Council on Ethical & Judicial Affairs, Am. Med. Ass'n, Report 2-I-06, *Placebo Use in Clinical Practice (2006)* [hereinafter *AMA Report*] (on file with the Yale Law & Policy Review).

4. While the Code of Medical Ethics does not itself carry the force of law, *see, e.g.,* *Bryant v. Hilst*, 136 F.R.D. 487, 492 (D. Kan. 1991), a number of courts have given the Code particular weight in resolving issues that turn on norms of professional conduct in the area of informed consent, *see* *Ketchup v. Howard*, 543 S.E.2d 371, 377 (Ga. Ct. App. 2000) (stating that the AMA's Code of Medical Ethics "reflect[s] the standard of care of the profession on the issue of informed consent"); *Culbertson v. Mernitz*, 602 N.E.2d 98, 103 (Ind. 1992) ("The . . . Code of Medical Ethics, as prepared by the Council on Ethical and Judicial Affairs of the American Medical Association, sets forth the medical profession's standard on informed consent."); *see also* *Marsingill v. O'Malley*, 58 P.3d 495, 504-05 (Alaska 2002) (quoting the AMA's Code of Medical Ethics on physician disclosure); *Matthies v. Mastromonaco*, 733 A.2d 456, 463-64 (N.J. 1999) (same).

5. *See infra* Sections II.B-D.

6. In many states, physicians can be sanctioned for violating the profession's ethical standards. *See, e.g.,* N.C. GEN. STAT. ANN. § 90-14(a) (West 2005) (permitting the state medical board to suspend or revoke the license of physicians who fail to conform to "the ethics of the medical profession, irrespective of whether or not a patient is injured thereby"); OR. REV. STAT. §§ 677.188-.190 (2005) (stating that physicians can be disciplined for "[u]nprofessional or dishonorable conduct," which is defined to include "[a]ny conduct or prac-

other theories of law.⁷ I will argue, contra the AMA, that given current knowledge of placebo effects and patient preferences, we should not categorically prohibit the deceptive use of placebos.

The deceptive use of placebos by clinicians raises a number of legal issues that have received surprisingly little scholarly attention.⁸ These issues are particularly hard to resolve because there is no safe harbor for even the most conscientious practitioners: Using placebos deceptively is thought to threaten patient autonomy, while deliberately not using them deprives patients of a potentially cheap, safe, and effective way of treating pain and other symptoms.⁹ Although there is a substantial literature on the use of

...tice contrary to recognized standards of ethics of the medical or podiatric profession"); Kenneth Baum, "To Comfort Always": *Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 72 (2001) (noting the statutory incorporation of medical ethics provisions into some state medical practice acts); see also Ben A. Rich, *A Placebo for the Pain: A Medico-Legal Case Analysis*, 4 PAIN MED. 366 (2003) (recounting an instance in which healthcare practitioners faced potential professional disciplinary proceedings for deceptively administering placebo treatment).

7. For example, depending on the facts, doctors who prescribe placebos might also be liable for breach of fiduciary duty, breach of contract, or fraud. See *infra* notes 235-246 and accompanying text. They may also face criminal liability for battery or for selling simulated controlled substances. See *infra* note 236 and accompanying text. This paper focuses almost exclusively on informed consent theories of liability because that is where the AMA focuses its concerns and because informed consent theories of liability are now likely to provide sufficient, though not exclusive, grounds for finding doctors liable.
8. I have found only two articles in the legal literature that focus specifically on the use of placebos in clinical practice. See Kathleen M. Boozang, *The Therapeutic Placebo: The Case for Patient Deception*, 54 FLA. L. REV. 687 (2002); Marshall B. Kapp, *Placebo Therapy and the Law: Prescribe with Care*, 8 AM. J.L. & MED. 371, 375 (1983). The issue also receives some attention in W. John Thomas, *Informed Consent, the Placebo Effect, and the Revenge of Thomas Percival*, 22 J. LEGAL MED. 313, 346-47 (2001). I have found only one article in the medical literature that explores the legal issues in any depth. See Rich, *supra* note 6.
9. A number of books about the placebo effect contain discussions of ethical issues raised by placebo use. See HOWARD BRODY, *PLACEBOS AND THE PHILOSOPHY OF MEDICINE: CLINICAL, CONCEPTUAL, AND ETHICAL ISSUES* (1980); DANIEL E. MOERMAN, *MEANING, MEDICINE, AND THE "PLACEBO EFFECT"* (2002); *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION* (Anne Harrington ed., 1997); *PLACEBO: THEORY, RESEARCH, AND MECHANISMS* (Leonard White et al. eds., 1985); *THE SCIENCE OF THE PLACEBO: TOWARD AN INTERDISCIPLINARY RESEARCH AGENDA* (Harry A. Guess et al. eds., 2002); ARTHUR K. SHAPIRO & ELAINE SHAPIRO, *THE POWERFUL PLACEBO: FROM ANCIENT PRIEST TO MODERN PHYSICIAN* (1997); W. GRANT THOMPSON, *THE*

placebos in medical experiments,¹⁰ research subjects are almost always informed that they may receive placebos. Such research does not involve deception. By contrast, in the clinical context, patients are rarely told that they are receiving placebos because doing so would reduce the therapeutic value of the proposed treatment.¹¹

If doctors were to actually abide by the AMA prohibition on deceptive placebo use, the policy would dramatically affect medical practice. Deceptive placebo use—described as one of medicine’s “dirty little secrets”¹²—probably occurs more often than one would expect. Some placebos, like sugar pills or saline injections, are given to patients even though they contain no active ingredients at all. A study at a Canadian teaching hospital from the early 1980s found that 80% of doctors and nurses had administered placebos, consisting more than nine times out of ten of sterile water injections.¹³ The study estimated that about 240 patients at the hospital each year were given inert substances as treatments.¹⁴ More recent research from other countries suggests that placebos, in one form or another, are still frequently prescribed.¹⁵

While doctors occasionally give patients pure placebos like sugar pills and saline injections, they far more frequently prescribe ordinary, active pharmaceuticals for conditions that are not pharmacologically treated by the prescribed drugs. For example, doctors sometimes prescribe antibiotics

PLACEBO EFFECT & HEALTH: COMBINING SCIENCE & COMPASSIONATE CARE (2005).

10. See, e.g., Sharona Hoffman, *The Use of Placebos in Clinical Trials: Responsible Research or Unethical Practice?*, 33 CONN. L. REV. 449 (2001); Kenneth J. Rothman & Karin B. Michels, *The Continuing Unethical Use of Placebo Controls*, 331 NEW ENG. J. MED. 394 (1994).
11. See *infra* Subsection II.A.1.
12. E-mail from Paul Arnstein, Assoc. Professor of Cmty. Health, Boston Coll., to Adam J. Kolber (July 20, 2006, 08:21:38 EDT) (on file with the Yale Law & Policy Review).
13. Gerald Gray & Patrick Flynn, *A Survey of Placebo Use in a General Hospital*, 3 GEN. HOSP. PSYCHIATRY 199, 200-01 (1981).
14. *Id.* at 200.
15. I provide an in-depth analysis of existing survey data on placebo use in the United States and elsewhere in Section II.B. By way of anecdotal data, Paul Arnstein states that at a recent “national conference, we asked by a show of hands how many nurses had seen an order for placebos written[.] Just about all of the 150 in attendance raised their hand. When asked how many had administered placebos, about 80% had.” E-mail from Paul Arnstein, Assoc. Professor, Cmty. Health, Boston Coll., to Adam J. Kolber (July 20, 2006, 08:21:38 EDT) (on file with the Yale Law & Policy Review).

or vitamins in order to generate placebo effects.¹⁶ In such cases, the antibiotic or vitamin is deemed an “impure placebo.” The use of impure placebos can be difficult to detect because the prescribed medication has a pharmacological effect on *some* illnesses, and doctors may be able to provide plausible-sounding medical rationales for prescribing impure placebos. The prescription of impure placebos is arguably more suspect than the prescription of pure placebos because the practice is harder to detect and because it carries the greater risk of patient side effects that are frequently associated with active medications. In the case of antibiotics, for example, overprescription threatens *everyone’s* ability to resist bacterial infections.¹⁷ The AMA Code of Medical Ethics now prohibits deceptive administration of both pure and impure placebos.

In the past, researchers estimated that “35 to 45 percent of all prescriptions are for substances that are incapable of having an effect on the condition for which they are prescribed.”¹⁸ While these numbers do not necessarily reflect instances of deceptive placebo administration, more recent data suggest that deceptive placebos, in one form or another, are still a common feature of medical practice.¹⁹ In this Article, I describe the legal and ethical issues raised by deceptive placebos and argue against categorical prohibitions on their use like the one adopted by the AMA. Deceptive placebos have genuine therapeutic benefits, and the AMA should not have prohibited them without more evidence that they are harmful. Too little is known about the science of placebos, as well as the sociology of patient preferences, to warrant a categorical prohibition at this time.

In Part I, I provide background on what placebos are, how they are thought to work, and the extent to which they hold promise as a therapy in clinical settings. In Part II, I describe why deception is needed to maximize placebo efficacy and why such deception raises questions about the legality of deceptive placebo administration. While there are no published opinions

16. See Rebecca K. Schwartz et al., *Physician Motivations for Nonscientific Drug Prescribing*, 28 *SOC. SCI. & MED.* 577, 577-79 (1989) (surveying doctors with suspicious prescribing practices and observing that 24% of this group admitted to intentionally prescribing antibiotics or other active drugs in order to obtain placebo effects).

17. See Jeffrey A. Linder et al., *Antibiotic Treatment of Children with Sore Throat*, 294 *JAMA* 2315, 2321 (2005) (providing evidence of antibiotic overprescription and noting the risk of bacterial resistance).

18. Sissela Bok, *The Ethics of Giving Placebos*, 231 *SCI. AM.* 17, 18 (1974) (reviewing the literature); cf. Laura Spinney, *Purveyors of Mystery*, *NEW SCIENTIST*, Dec. 16-22, 2006, at 42 (quoting Dr. Patrick Lemoine as stating that the “most reliable estimates suggest that around 35 to 40 per cent of all official prescriptions are impure placebos”).

19. See *infra* Section II.B.

in which a doctor has been found liable for deceptively administering a placebo, deceptive placebo administration arguably violates doctors' legal obligations to obtain patient informed consent. While there are reasons to think placebo deception might have violated these obligations even before the new AMA provision, I will suggest that there used to be plausible arguments in both directions. By weighing in on the matter, the AMA's provision may well have tipped the scales against the practice of placebo deception.

In Part III, I explain why the AMA's categorical prohibition of deceptive placebos was ill advised. First, prohibition is inconsistent with the preferences of many patients. Given that many patients seem willing to receive placebos deceptively, arguments that deceptive placebos threaten patient autonomy ought not to be accepted uncritically. Second, the categorical prohibition is overinclusive because it prohibits a great deal of behavior that we think ought to be permissible, such as deceptive placebo use that is safeguarded to promote patient well-being. Third, a categorical prohibition like the AMA's may have unintended consequences by, for example, dictating informed consent requirements for birth control pills, which typically include a week of placebos as part of a monthly pill-taking regimen. Fourth, a categorical prohibition on deceptive placebo use provides incentives to doctors who would have prescribed pure placebos to prescribe impure placebos instead, because the latter practice is more difficult to detect. By encouraging doctors to prescribe impure placebos, not only are patients still deceived, they also have a greater risk of harmful side effects and must pay for more expensive treatment.

Lastly, I argue that the concern over placebo administration mistakenly focuses too much on the harms of deception in individual cases. The more salient concern is that placebo deception is a scarce medical resource. The more frequently that doctors deceive patients, the more that patients become aware of the practice of placebo deception and the weaker the placebo effect becomes. The best reason to limit placebo use is that placebos must be administered sparingly, else their power will be self-defeating, particularly in a world where patients have greater access to medical information and have become increasingly savvy about their own medical treatment. But even if deceptive placebos should only be used sparingly, it is by no means clear that a categorical prohibition is required to accomplish that goal.

In Part IV, I discuss the near absence of court cases challenging deceptive placebo administration and explain why this fact should give us pause before we prohibit the practice. I also propose an interdisciplinary research agenda that would enable us to develop more targeted policies about when and how to regulate placebo deception. As I believe that further evidence could potentially justify a categorical prohibition on deceptive placebos, my defense of clinical placebo deception is quite limited. I end by noting that the issues raised by deceptive placebo use are just a small part of a much bigger debate concerning beneficent deception in general.

I. BACKGROUND

Placebo deception raises interesting legal and ethical issues only if there are, in fact, placebo effects that are sufficiently beneficial to justify patient deception. In this Part, I describe the placebo effect, the AMA's ban on deceptive placebos, and evidence that placebos can generate substantial improvements in some patient conditions.

A. The Meaning of "Placebo" and "Placebo Effect"

It is difficult to precisely define the term "placebo."²⁰ According to the definition adopted by the AMA, a placebo is "a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated."²¹ Under this description, physicians may believe that a placebo treatment is quite therapeutic, provided they do not believe it to have a "specific" effect on the condition for which they prescribe it. Thus, the AMA's definition shifts the difficult definitional issues from the word "placebo" to the word "specific."

Non-specific effects of placebos include the changes placebos cause by way of the patient's expectations of feeling better, selective attention to symptoms, and conditioned responses to treatment.²² While these effects likely have quite specific neurological mechanisms, the AMA probably deems them "non-specific" because they do not proceed through the kind of pharmacological pathways that physicians and drug companies typically seek to use to heal patients.²³ A 1997 publication of the National Institutes of Health avoids the language of "specific efficacy," stating that the placebo effect is the "positive healing effect resulting from the use of any healing

20. THOMPSON, *supra* note 9, at 18 (identifying eighteen different dictionary entries for the word "placebo" from 1785 to 2001); BOOZANG, *supra* note 8, at 692-99 (discussing competing definitions of the term).

21. AMA RECOMMENDATIONS, *supra* note 3, at 1.

22. Donald D. Price & Howard L. Fields, *The Contribution of Desire and Expectation to Placebo Analgesia: Implications for New Research Strategies*, in *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 117.

23. Walter Brown states that a non-specific effect "probably refers, among other things, to an imprecise or undefined mode of action or an effect on more than one condition." Walter A. Brown, *Placebo as a Treatment for Depression*, 10 *NEUROPSYCHOPHARMACOLOGY* 265, 266 (1994); see also Richard R. Bootzin & Opher Caspi, *Explanatory Mechanisms for Placebo Effects: Cognition, Personality and Social Learning*, in *THE SCIENCE OF THE PLACEBO*, *supra* note 9, at 108, 110-11 (stating that "[a]lthough the placebo effect stems from incidental elements of treatments, the effects of the placebo can be highly specific" (footnote omitted)); BOOZANG, *supra* note 8, at 698 nn.58-59 (reviewing various definitions of "specific" efficacy).

intervention . . . that is presumed to be mediated by the symbolic effect of the intervention upon the patient.”²⁴ Of course, this description still forces us to confront what it means for a treatment to be mediated by a symbolic effect.

In some cases, patient placation may be, or may appear to be, a kind of placebo effect. Suppose that a patient begs his doctor to prescribe an antibiotic, and the doctor does so, even though the doctor believes the patient to have a viral infection that will not respond to antibiotics. Under the AMA definition, the doctor has prescribed a placebo, assuming that the doctor believes that the antibiotic will have no specific effect on the patient’s condition. Yet what if the only effect of the placebo is to make the patient less anxious? Is the patient’s reduced anxiety a placebo effect or just a consequence of patient placation? We may be hesitant to deem his anxiety reduction a placebo effect because we do not ordinarily think of anxiety as a symptom of viral infections. On the other hand, were this patient to go to a psychiatrist for treatment of anxiety, we would likely deem the same anxiety reduction from a placebo to be a placebo effect. If the patient’s overall condition improves, the distinction may be unimportant.

Notably, the AMA’s definition of placebo limits its scope to “substance[s]” provided to patients. Most researchers construe placebos more broadly to include medical procedures, like sham surgery, where an intervention makes a person feel better, if at all, only through a placebo effect.²⁵ Some also deem certain features of the doctor-patient relationship to have placebo-like qualities (e.g., a doctor’s confidence-inducing white coat, fancy diploma, and reassuring attention), even though these features are not considered treatments at all in the conventional sense.²⁶

There is an interesting flip side to the placebo effect, called the “nocebo effect.” The nocebo effect refers to “the causation of sickness (or death) by expectations of sickness (or death) and by associated emotional states.”²⁷

24. OFFICE OF ALTERNATIVE MED., NAT’L INSTS. OF HEALTH, 4 COMPLEMENTARY & ALTERNATIVE MED. NIH 3 (1997); see also Bootzin & Caspi, *supra* note 23, at 109 (citing the NIH publication).

25. For example, Arthur and Elaine Shapiro use the term “placebo” to refer to “any therapy prescribed knowingly or unknowingly . . . for its therapeutic effect on a symptom or a disease, but which actually is ineffective or not specifically effective for the symptom or disorder being treated.” Arthur K. Shapiro & Elaine Shapiro, *The Placebo: Is It Much Ado About Nothing?*, in *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 12.

26. See Bootzin & Caspi, *supra* note 23, at 109; Boozang, *supra* note 8, at 720 (describing the view of “meaning model” adherents).

27. Robert A. Hahn, *The Nocebo Phenomenon: Scope and Foundations*, in *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 56; see also Sissela Bok, *Ethical Issues in Use of Placebo in Medical Practice and*

When patients believe they are receiving a treatment with a certain negative effect, the effect is more likely to eventuate.²⁸ For example, “80 percent of hospitalized patients given sugar water and told that it was an emetic [a substance that induces vomiting] subsequently vomited.”²⁹

Some determine whether or not a treatment is a placebo by objectively examining the effects of the treatment on a patient.³⁰ Others identify placebos by assessing the placebo administrator’s subjective intent to use a treatment to obtain a placebo effect. The AMA adopts the latter approach, focusing on whether a physician *believes* a substance to have specific effects on a patient’s condition.³¹ To illustrate the difference, consider the time before it was known that aspirin reduces the risk of a heart attack. Suppose a doctor then prescribed aspirin for a cardiac patient solely in the hopes of generating a placebo effect. Under these circumstances, the doctor prescribed a placebo according to the AMA definition because the physician believed (albeit incorrectly) that aspirin would have no specific pharmacological effect on the patient’s condition. By contrast, this would not have been an instance of placebo administration from an objective perspective, because the aspirin really would have had specific effects on the patient’s condition.

As noted in the Introduction, certain placebos, like sugar pills or saline injections, are *pure* placebos, which means that they have no pharmacological or other specific effects on the body (or, at least, that they are not in-

Clinical Trials, in *THE SCIENCE OF THE PLACEBO*, *supra* note 9, at 53, 58 (noting that the term “nocebo effect” is used by some “to designate undesirable side effects of a placebic treatment that are not intended by the caregiver who is providing it in the hope of its bringing about positive effects; others limit the term to conditions where the subject expects a negative outcome, as in the extreme case of ‘voodoo death’”).

28. Irving Kirsch, *Specifying Nonspecifics: Psychological Mechanisms of Placebo Effects*, in *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 166, 176; *see also* Thomas R. Wehrauch, *Placebo Treatment Is Effective Differently in Different Diseases—But Is It Also Harmless?: A Brief Synopsis*, 10 *SCI. & ENGINEERING ETHICS* 151, 152 (2004) (noting that, in controlled research studies, the side effects of those taking placebos are often similar to the side effects of those receiving the experimental treatment).
29. Hahn, *supra* note 27, at 57.
30. For example, Arthur and Elaine Shapiro focus on a treatment’s actual effects on the body regardless of whether the placebo effect is sought “knowingly or unknowingly.” Shapiro & Shapiro, *supra* note 25, at 12; *see also* Boozang, *supra* note 8, at 696-97 (“Significant to [Arthur] Shapiro’s definition is an objective determination of whether something is a placebo; the physician’s intent or belief being irrelevant . . .” (footnote omitted)).
31. AMA RECOMMENDATIONS, *supra* note 3, at 1.

tended to have specific effects).³² By contrast, *impure* placebos are ordinary pharmaceuticals or other treatments that have specific effects on some medical conditions but no specific effects on the condition for which they are administered (or, at least, that they are not intended to have specific effects on that condition).³³ For example, a doctor convinced that his patient has a viral infection who nevertheless gives the patient an antibiotic to treat the infection has administered an impure placebo because antibiotics do not ordinarily treat viral infections. The distinction between pure and impure placebos is not very robust, for even sugar pills will have specific, pharmacological effects on blood sugar in a diabetic.³⁴

B. Anecdotal Benefits and Harms of Placebos

Anecdotal accounts of deceptive placebo administration illuminate both potential benefits and potential perils of placebo deception. For example, Patrick Lemoine, a French psychiatrist and author of *Le Mystère du Placebo*,³⁵ notes that magnesium is often prescribed for anxiety in Europe in order to obtain a placebo effect.³⁶ Magnesium has no specific pharmacological effect on anxiety, although “[r]are conditions resulting from a deficiency of magnesium produce some symptoms very similar to those of anxiety.”³⁷ Lemoine “confess[es]” that he prescribes magnesium to patients with high levels of anxiety, noting that his “patients are generally satisfied.”³⁸ Moreover, he sometimes has “the impression that not only do they show a remarkable improvement, but their relapse is almost immediate if the treatment is interrupted.”³⁹ So long as Lemoine believes that magnesium has no specific pharmacological effect on anxiety, as seems to be the case, Lemoine’s use of magnesium to treat anxiety would fall under the AMA’s definition of a placebo.⁴⁰

32. See SHAPIRO & SHAPIRO, *supra* note 9, at 2 (noting that placebos can be “inert (such as a sugar pill) or active (such as an ineffective drug or a drug used at an ineffective dosage)”).

33. *Id.*

34. Bootzin & Caspi, *supra* note 23, at 113.

35. PATRICK LEMOINE, *LE MYSTÈRE DU PLACEBO* (2d ed. 2006).

36. Laura Spinney, *Purveyors of Mystery*, *NEW SCIENTIST*, Dec. 16, 2006, at 42 (interviewing Patrick Lemoine).

37. *Id.*

38. *Id.*

39. *Id.*

40. Remarkable accounts of placebo improvement have even been reported for sham surgery (which, not being a “substance,” is technically not addressed by the AMA prohibition). A *New York Times* article in 2000 tells the story of Syl-

By contrast, doctors sometimes deceptively give placebos to patients that they perceive as too persistent in seeking medical attention or as faking symptoms. Such deception can be quite harmful. Sissela Bok recounts the following story of deceptive placebo administration gone frighteningly awry:

“I didn’t know there could be pain so great,” a man once wrote me from prison. He had repeatedly complained to the staff physician of strong pain in his left kidney area and had tried to explain that the shots prescribed for his pain had brought no relief. When he tried once again to ask for help, the physician, who said he was in a hurry to go home for the evening, prescribed yet another injection. “I looked to see what medication he ordered and it was water.” The prisoner’s protests and mounting distress finally convinced those in charge to send him to a hospital. He was found to have an unusually painful kidney stone and was given immediate care and pain relief. “But to realize that the doctor was prescribing water for this will always leave a memory,” he wrote, “and I don’t think I would ever trust a doctor again.”⁴¹

vester Colligan, a seventy-six-year-old veteran who had knee trouble for the preceding five years. His doctor suggested that he might have arthritis and referred him to J. Bruce Moseley, a surgeon who is also the team physician for the Houston Rockets professional basketball franchise. Moseley conducted a pilot study to test the efficacy of arthroscopic knee surgery by comparing those who had the surgery (where the knee joint is scraped and rinsed) to those who had a sham version of the surgery (where sedatives are administered and knee incisions are made so it later seems to the patient as if ordinary surgery occurred). Colligan, who had only the sham treatment, could not have been happier with the results:

“I was very impressed with [Moseley], especially when I heard he was the team doctor with the Rockets,” says Colligan Colligan doesn’t sound all that at ease with the term placebo, but he does know his surgery consisted of only shallow incisions. More important, he knows that he has no pain in his knee now and that he can mow his yard again and walk wherever he wants. “The surgery was two years ago and the knee never has bothered me since,” he says. “It’s just like my other knee now. I give a whole lot of credit to Dr. Moseley. Whenever I see him on the TV during a basketball game, I call the wife in and say, ‘Hey, there’s the doctor that fixed my knee!’”

Margaret Talbot, *The Placebo Prescription*, N.Y. TIMES, Jan. 9, 2000, § 6 (Magazine), at 35-36. While Colligan was not deceived about the placebo nature of the surgery, the *New York Times* account suggests that his *understanding* of the procedure was incomplete. Yet, if the sham treatment was the cause of his improvement, we should not entirely discount its therapeutic value.

41. Bok, *supra* note 27, at 57.

Mike Woods, a veteran of the Persian Gulf War, tells a similar story about his own experiences with concealed placebos. In 1991, Woods returned from the Gulf exhibiting symptoms that he associates with his military service, including seizures, headaches, and memory lapses.⁴² As part of his treatment, a doctor in the Department of Veterans Affairs health system gave him a prescription for an inactive substance called “obecalp,” which is “placebo” spelled backwards.⁴³ In 2005 congressional testimony, Woods claimed that this experience provides additional evidence that the government has not taken seriously post-Gulf War illnesses.⁴⁴

C. Placebo Efficacy

The placebo effect has purportedly “been demonstrated in thousands of studies.”⁴⁵ One of the most influential was Henry K. Beecher’s 1955 article in the *Journal of the American Medical Association*, which claimed that, on average, more than 35% of patients are “satisfactorily relieved by a placebo.”⁴⁶ Looking at fifteen studies with a total of more than one thousand subjects,⁴⁷ he claimed to find powerful evidence of placebo effects in the treatment of conditions that involve subjective responses, including post-operative

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42. Michael McLeod, *After the Storm: The Persian Gulf War: 10 Years Later*, ORLANDO SENTINEL, Jan. 14, 2001, at A1.
43. *Gulf War Veteran Gets Placebos Instead of Real Medicine*, WSOCTV.COM, Feb. 23, 2006, <http://www.wsocvtv.com/specialreports/7373238/detail.html>. The prescription of “obecalp” was also the subject of an episode of the television show *ER*. See *ER: Shifts Happen* (NBC television broadcast Oct. 23, 2003); see also *ER Headquarters, Shifts Happen*, <http://www.erheadquarters.com/episodes/10/10205.htm> (last visited Oct. 22, 2007) (describing the episode).
44. *Examining VA Implementation of the Persian Gulf War Veterans Act of 1998: Hearing Before the Subcomm. on National Security, Emerging Threats, and International Relations of the H. Comm. on Government Reform*, 104th Cong. 144 (2005) (statement of Mike Woods); see also Claire Panosian Dunavan, *A Placebo, Yes, But Not Harmless*, L.A. TIMES, Dec. 12, 2005, at F6 (stating that in the 1970s, “a few doctors at my university hospital treated patients with saline injections and little blue sugar pills,” sometimes writing “obecalp” on patient prescriptions). An anesthesiologist has described the extensive use of deceptive placebos at a medical center associated with a major research institution during the time he spent there as a medical intern from 1974 to 1975. See *BehindTheMedspeak: Obecalp*, bookofjoe.com, http://www.bookofjoe.com/2004/11/behindthemedspe_3.html (last visited Nov. 2, 2004).
45. Howard Spiro, *Clinical Reflections on the Placebo Phenomenon*, in *THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 37, 40.
46. Henry K. Beecher, *The Powerful Placebo*, 159 JAMA 1602, 1604-05 (1955).
47. *Id.* at 1604, tbl.2.

wound pain, cough, mood, angina, headache, seasickness, anxiety, and the common cold.⁴⁸

Unfortunately, Beecher's influential study was also quite flawed and likely overstated the magnitude of what we typically call placebo effects.⁴⁹ Most significantly, Beecher's study failed to adequately recognize that most ailments improve over time, quite independent of the placebo effect.⁵⁰ Thus, even if 35% of patients improved their condition while taking a placebo, some substantial percentage would have improved over time without it. Beecher gave the placebo effect too much credit by failing to discount the effect of natural healing over time.⁵¹

To better assess the placebo effect, we should compare those taking placebos to a group receiving no treatment at all. Indeed, in a 2001 issue of the *New England Journal of Medicine*, two Danish researchers, Asbjørn Hróbjartsson and Peter C. Gøtzsche, published a meta-analysis of 114 medical experiments where a "no treatment" group was included.⁵² They found that most previous studies could not distinguish the beneficial effects of placebos in clinical trials from natural healing over time and from regression to the mean.⁵³ The researchers claimed to find "little evidence that placebos in

48. *Id.* at 1604-05.

49. This point is most clearly made in Gunver S. Kienle & Helmut Kiene, *The Powerful Placebo Effect: Fact or Fiction?*, 50 J. CLINICAL EPIDEMIOLOGY 1311, 1316 (1997).

50. Bootzin & Caspi, *supra* note 23, at 112.

51. Beecher's study also failed to account for certain statistical effects that are likely to arise in research studies. For example, if patients in these studies are more likely to enroll "when their pain is at or near its greatest intensity, then the statistical phenomenon of regression to the mean predicts that their pain level is likely to be lower when they return for a second pain assessment." Hoffman et al., *supra* note 1, at 251. Furthermore, patients in clinical studies, perhaps by virtue of incentives to please investigators, may consciously or unconsciously report more severe symptoms at the beginning of a study and less severe symptoms at the end. See Bootzin & Caspi, *supra* note 23, at 113. Doing so would overstate the effect of both experimental and placebo therapies (though not necessarily to the same degree).

52. Asbjørn Hróbjartsson & Peter C. Gøtzsche, *Is the Placebo Powerless?: An Analysis of Clinical Trials Comparing Placebo with No Treatment*, 344 NEW ENG. J. MED. 1594, 1595 (2001).

53. *Id.* at 1594.

general have powerful clinical effects,"⁵⁴ though they did find significant placebo effects related to pain reduction.⁵⁵

The Hróbjartsson and Gøtzsche study has itself been criticized on a variety of methodological grounds.⁵⁶ Importantly, the study examined placebo effects in medical experiments, where subjects are aware that they may or may not be receiving placebos. In the clinical context, placebo effects are likely to be stronger because patients are led to believe that they are receiving an active medication. Nevertheless, the Danish study is likely correct that the scope of the placebo effect is smaller than many have claimed, as is the range of symptoms that can be treated effectively with placebos.

In any event, the Danish researchers did find significant placebo effects in the treatment of pain, which is consistent with other experiments demonstrating placebo analgesia. For example, a 1984 study in *Nature* found that the deceptive administration of placebos had about the same pain-relieving effect as the hidden administration of eight milligrams of morphine.⁵⁷ In fact, when placebos are prescribed in clinical contexts, they are frequently prescribed for pain relief. One study reported that approximately 90% of the pure placebos administered at a Canadian teaching hospital were given to treat pain and its associated symptoms.⁵⁸ Furthermore, in those cases where placebos were used, head nurses reported success with the first administration in eight of ten cases, and approximately half of patients continued to have a placebo response after more than three administrations.⁵⁹

There is also a growing body of neuroscientific evidence supporting the view that placebos can generate substantial pain relief that is much like the pain relief from conventional analgesics. As noted, a number of brain imaging studies suggest that the pathways of placebo pain relief in the brain

54. *Id.* at 1599; see also Kienle & Kiene, *supra* note 49, at 1316 (“[W]e have not found any reliable demonstration of the existence of placebo effects.”).

55. Hróbjartsson & Gøtzsche, *supra* note 52, at 1597, 1599.

56. See, e.g., Irving Kirsch, *Yes, There Is a Placebo Effect, But Is There a Powerful Antidepressant Drug Effect?*, 5 PREVENTION & TREATMENT 22 (2002); Penelope J. Greene et al., *The Powerful Placebo: Doubting the Doubters*, 17 ADVANCES IN MIND-BODY MED. 298, 302 (2001) (citing methodological concerns related to study selection, publication bias, general concerns about meta-analysis in this context, and the ways in which the researchers selected outcome measures) David Spiegel et al., *Is the Placebo Powerless?*, 345 NEW ENG. J. MED. 1276 (2001).

57. Jon D. Levine & Newton C. Gordon, *Influence of the Method of Drug Administration on Analgesic Response*, 312 NATURE 755, 755 (1984).

58. Gray & Flynn, *supra* note 13, at 201.

59. *Id.* at 201-02.

largely overlap with the pathways of pain relief from standard opioids.⁶⁰ This research supports older studies which found that naloxone, a drug that blocks opioid analgesia, also blocks placebo analgesia.⁶¹ Thus, neuroscience research supports the view that placebos reduce the subjective distress of pain and that placebo relief is, perhaps needless to say, real relief.

The analgesic value of placebos seems to derive in large measure from the expectations of relief they create.⁶² If pain is a signaling mechanism that tells us when our bodies need rest or attention, then the expectation that our bodies will get better quite possibly reduces the intensity of those signals.⁶³ In addition, placebos may generate conditioned responses that “arise after an individual is repeatedly exposed to pairings of neutral sensory cues (the shape of a pill, the environment of a doctor’s office) with effective treatment manipulations.”⁶⁴ We therefore have both strong empirical data demonstrating placebo effects along with plausible theories that explain placebo efficacy.

Furthermore, there is good reason to believe that deceptive placebos can assist in patient diagnosis. For example, in Subsection III.C.1, I will describe how placebos can help distinguish seizures associated with epilepsy, a neurological disorder, from the attacks associated with psychoseizures, a psychological disorder. Interestingly, those who doubt the diagnostic value of placebos sometimes emphasize the powerful efficacy of placebos in a wide swath of patients. They claim that because people respond to placebos under so many conditions, placebos cannot be used to make differential diagnoses.⁶⁵ For example, one article notes:

[A] placebo response (that is, relief of pain) tells nothing about the origin of pain. The placebo is a powerful tool for pain control in susceptible persons, regardless of the origin of the pain. . . . Thus malingerers or drug addicts do not have a greater likelihood of being relieved by a placebo. Indeed the impression given by most of

60. See *supra* note 1.

61. Hoffman et al., *supra* note 1, at 258-59.

62. *Id.* at 257.

63. See NICHOLAS HUMPHREY, *Great Expectations: The Evolutionary Psychology of Faith-Healing and the Placebo Effect*, in *THE MIND MADE FLESH: ESSAYS FROM THE FRONTIERS OF PSYCHOLOGY AND EVOLUTION* 255, 273-74 (2002).

64. Hoffman et al., *supra* note 1, at 257.

65. Jeffrey T. Berger, *Placebo Medication Use in Patient Care: A Survey of Medical Interns*, 170 *WEST J. MED.* 93, 94 (1999) (suggesting that placebos are “useless . . . in assessing a complaint of pain”); James S. Goodwin et al., *Knowledge and Use of Placebos by House Officers and Nurses*, 91 *ANNALS INTERNAL MED.* 106, 109 (1979).

the studies is that such patients are less likely to be placebo responders.⁶⁶

The fact that patients can be relieved by placebos under a variety of circumstances, however, does not preclude the possibility that placebos can aid in diagnosis. In fact, the very suggestion that malingerers and drug addicts may have a weaker response to placebos is evidence that placebos may have diagnostic value. If there are consistent differences in the *magnitude* of placebo response that correlate with diagnosis, then placebos can potentially reveal information pertinent to diagnosis.

In any event, the AMA's explanation for its new policy never denies the efficacy or diagnostic value of placebos. Rather, the AMA is concerned with the legal and ethical implications of using a treatment that requires patient deception. Thus, in order to examine the relevant legal and ethical issues, for the rest of this Article we may safely assume the truth of the prevailing view that there are clinically significant placebo effects, particularly for pain and possibly for other symptoms or conditions as well.

D. Placebo Deception

The AMA now permits placebo use only when “the patient is informed of and agrees to its use.”⁶⁷ So, the AMA clearly prohibits outright lies about the nature of a placebo treatment. For example, it violates the AMA rule to give patients sugar pills and tell them that they are receiving Valium. I believe that the AMA requirement more broadly prohibits certain omissions and half-truths where doctors exploit informational asymmetries between doctor and patient to help generate a placebo effect.⁶⁸ So, suppose that a doctor gives a patient unmarked sugar pills and says, “A number of research studies suggest that these pills can help your pain.” While the doctor has not uttered any factually false statements, assuming the patient accepts the pills under the conventional understanding that they contain active medication, the patient has nevertheless been deceived. In such cases, it would be incorrect to say that the patient was “informed of” and “agrees to” use the placebo, as the AMA requires.⁶⁹

66. See Goodwin et al., *supra* note 65, at 109.

67. AMA RECOMMENDATIONS, *supra* note 3, at 1.

68. See generally Frederick Schauer & Richard J. Zeckhauser, *Paltering* (John F. Kennedy Sch. of Gov't, Working Paper No. RWP07-006, 2007), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=832634 (discussing the legal status of “paltering,” a term used to refer to “intentionally deceptive practices such as fudging, twisting, shading, bending, stretching, slanting, exaggerating, distorting, whitewashing, and selective reporting”).

69. It would seem odd if the AMA were concerned about patient autonomy in a way that permitted statements about placebos that were factually true but

Filling in the precise contours of our background conventions concerning treatment disclosure turns out to be quite difficult. Even when doctors deliberately withhold knowledge from patients in order to capitalize on placebo effects, they are not necessarily deceiving them. Treatments exist on a spectrum ranging from those expected to create only a placebo effect to those for which the placebo effect is entirely irrelevant to the decision to prescribe. In many cases, treatments are prescribed for mixed reasons, including hopes of both specific and placebo effects. Suppose drug Z might have some pharmacological effect on a patient, but the probability is too low to justify the drug's possible side effects. The benefits of prescribing Z might exceed the costs, however, given both the chance of a pharmacological effect *and* the chance of a placebo effect.

In such a case, the placebo effect is treatment determinative. It is an essential part of the doctor's decision to prescribe the treatment. Deliberately failing to mention the placebo purpose of the treatment when the doctor would mention mechanisms of non-placebo relief might brush up against the borders of deception. The doctor would be concealing the placebo effect in order to bolster it. Most likely, however, our background conventions do not require disclosure in such cases. It would be rare indeed and probably ill advised for a doctor to say, "Take this medication. It may or may not help your cough directly, but, in any event, it will put you at ease and may divert your attention from your symptoms by way of a placebo effect." Such a discussion would undermine the very placebo effect that motivated the treatment. In any event, the AMA sidesteps some of the difficult questions about our background conventions by focusing on those cases where the placebo effect is the sole medical reason for prescription.

Finally, I will focus on situations that involve "therapeutic deception," meaning situations where a physician deceives a patient, believing that doing so is in the patient's best interest. By contrast, placebos can also be used to overcharge patients, to dispatch with troublesome or time-consuming patients, and to provide a patient with a short-term remedy at the expense of a more careful and thorough diagnosis and treatment regimen. There is no doubt that deceptive placebos, like any treatment, can be used for the wrong patient at the wrong time. In order to evaluate the AMA's categorical prohibition, however, it is important to determine whether deceptive placebos can *ever* be used at the right time.

II. DECEPTION AND THE LAW OF INFORMED CONSENT

Honesty was not considered an essential part of the healer-patient relationship until the second half of the twentieth century. In fact, the Code of Ethics of the American Medical Association in 1847 stated that doctors have

nevertheless deceptive. If, however, the AMA would permit such statements, then the scope of its ban is smaller than I take it to be in this Article.

a sacred duty “to avoid all things which have a tendency to discourage the patient and to depress his spirits,”⁷⁰ and it was not until the 1980s that the AMA’s Principles of Medical Ethics required doctors to “deal honestly with patients and colleagues.”⁷¹

Over the last fifty years or so, lawyers and bioethicists have increasingly emphasized the obligation of healthcare practitioners to respect the autonomous decisions of competent patients by obtaining their informed consent prior to treatment. Informed consent is said to be “perhaps the oldest and most basic legal implementation of bioethical principles.”⁷² According to the doctrine of informed consent, practitioners are required to make certain disclosures to patients prior to beginning medical procedures and to obtain the patient’s permission to proceed.⁷³ The right is “in part . . . a safeguard against being manipulated by caregivers who may be less than altruistic, less than competent in evaluating patients”⁷⁴ and may also be “in part a safeguard against health professionals engaging in deceit, no matter how benevolent in intent.”⁷⁵

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70. Bok, *supra* note 27, at 56 (quoting AM. MED. ASS’N, CODE OF ETHICS ch. I, art. I, para. 4 (1847)).
71. AM. MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS princ. II (1980); Bok, *supra* note 27, at 55. Note that this language has since been updated. AM. MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS princ. II (2001), available at <http://www.ama-assn.org/ama/pub/category/2512.html> (“A physician shall . . . be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.”).
72. Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 417 (2006); see also *id.* at 411-44 (arguing that the concept of autonomy perversely dominates contemporary bioethics).
73. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170 (Cal. Ct. App. 1957); *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent . . . is liable in damages.”); Paula Walter, *The Doctrine of Informed Consent: To Inform or Not To Inform?*, 71 ST. JOHN’S L. REV. 543 (1997) (describing the law of informed consent in New York State).
74. Bok, *supra* note 27, at 56.
75. *Id.* The New York Court of Appeals has held that doctors’ obligations to speak truthfully in regard to doctor-patient matters are so important that the obligation can extend to doctors’ communications with third parties, such as an insurance company. *Aufrichtig v. Lowell*, 650 N.E.2d 401, 404 (N.Y. 1995) (“[W]e conclude that because the . . . treating physician stands in a relation-

Howard Spiro has stated that “[t]he autonomy movement of the 1960s, built on the foundation of truth-telling, gave the quietus to placebos as it led to a general derision of the old-fashioned beneficent ‘deception’ that placebos seem to represent.”⁷⁶ What was once general derision, however, has now turned into clear civil liability. For some time, many hospitals and professional organizations have prohibited the deceptive use of placebos.⁷⁷ The new AMA provision, however, is particularly likely to make deceptive placebo use unlawful because some courts take the “Code of Medical Ethics, as prepared by . . . the American Medical Association, [to set] forth the medical profession’s standard on informed consent.”⁷⁸

In this Part, I discuss placebo deception and why it is necessary to deceive patients in order to maximize placebo efficacy. I then show that, prior to the AMA’s change to its ethics policy, it was not clear whether deceptive placebo administration would violate the doctrine of informed consent. In fact, to the best of my knowledge, no published cases have discussed the matter. Because there are no relevant precedents, courts are particularly likely to give weight to the AMA’s new provision. Thus, it is now more likely than ever that doctors who deceptively use placebos not only violate the Code but also invite legal liability and professional disciplinary actions.

A. Avoiding Deception

Before examining whether deceptive placebos necessarily violate obligations of informed consent, I address the suggestion that patients can still get the benefits of placebos without deception if doctors procure patients’ in-

ship of confidence and trust to his patient, he owed plaintiffs in this case a duty to speak the truth about her medical condition.”).

76. Spiro, *supra* note 45, at 39.

77. For hospital prohibitions on deceptive placebos, see, for example, ORLANDO REG’L HEALTHCARE, ETHICAL USE OF PLACEBOS (2005), <http://www.ashp.org/emplibrary/Useofplacebopolicy.pdf> (prohibiting deceptive placebo administration). For health professional organization prohibitions, see, for example, Mark Sullivan et al., *APS Position Statement on the Use of Placebos in Pain Management*, 6 J. PAIN 215 (2005); Am. Soc’y of Health-System Pharmacists, ASHP Policy Position: Ethics, http://www.ashp.org/s_ashp/doc1c.asp?CID=512&DID=7320#0517; and CANDICE C. COGGINS ET AL., AM. SOC’Y FOR PAIN MGMT. NURSING, POSITION STATEMENT ON USE OF PLACEBOS IN PAIN MANAGEMENT (2004), <http://www.aspmn.org/pdfs/Use%20of%20Placebos.pdf>.

78. *Culbertson v. Mernitz*, 602 N.E. 2d 98, 103 (Ind. 1992); see *Ketchup v. Howard*, 543 S.E.2d 371, 377 (Ga. Ct. App. 2000) (stating that the AMA’s Code of Ethics “reflect[s] the standard of care of the profession on the issue of informed consent”); see also *supra* note 4.

formed consent to *placebo* treatment.⁷⁹ According to the AMA, doctors can reveal to patients in advance the placebo nature of their treatments without “significantly diminish[ing] their clinical effectiveness,”⁸⁰ thereby only using placebos “in partnership with” patients.⁸¹ Furthermore, in the AMA’s view “[p]hysicians can avoid using a placebo, yet produce a placebo-like effect through the skillful use of reassurance and encouragement.”⁸² While I support research into both of these claims, I argue that concealed placebos almost certainly work better than revealed placebos. Supportive physician-patient relationships ought to be encouraged, but it is unlikely that such support obviates the need for prudent placebo deception.

1. *Revealed Placebos*

A number of researchers have suggested that patients can still get the benefits of pure placebos even when doctors reveal their inert nature.⁸³ This claim is ostensibly bolstered by a 1965 research study by Lee Park and Lino Covi in which fifteen adult “neurotic” outpatients were prescribed pure placebos for one week and were told exactly what they were receiving.⁸⁴ Each subject was told that “[m]any people with your kind of condition have also been helped by what are sometimes called ‘sugar pills,’ and we feel that a so-called sugar pill may help you, too.”⁸⁵ To make the point even clearer, researchers stated that “[a] sugar pill is a pill with no medicine in it at all. I think this pill will help you as it has helped so many others.”⁸⁶

One might expect that patients would be neither willing to participate in such an experiment nor capable of experiencing a beneficial placebo effect given what they were told. Surprisingly, however, fourteen of the fifteen subjects proceeded with the course of treatment, and only one did not because “her husband ridiculed and verbally attacked her for wasting her

79. See Boozang, *supra* note 8, at 720-24; Kapp, *supra* note 8, at 390-94.

80. AMA REPORT, *supra* note 3, at 2.

81. *Id.*

82. *Id.* at 3. Presumably, the term “skillful” would not extend to deceptive uses of reassurance.

83. See Boozang, *supra* note 8, at 720-24; Kapp, *supra* note 8, at 390-94.

84. Lee C. Park & Lino Covi, *Nonblind Placebo Trial*, 12 ARCHIVES GEN. PSYCHIATRY 336, 336-37 (1965).

85. *Id.* at 337.

86. *Id.*

money on ‘sugar pills.’”⁸⁷ Perhaps even more surprisingly, thirteen of the fourteen subjects improved, some of them quite significantly.⁸⁸

The Park and Covi study was, however, a short, small-scale experiment that did not account for the natural course of symptom improvement and has not been subsequently replicated.⁸⁹ Furthermore, an astonishing six of the fourteen patients told researchers that they believed they were receiving an active drug, even though they were explicitly told the contrary.⁹⁰ Thus, it is not clear that the Park and Covi subjects truly believed that they were receiving placebos. In an interesting case of deceptive jujitsu, one subject “felt that perhaps the doctor had told him he was receiving placebo so that he would think that he was helping himself, when actually the drug was the factor.”⁹¹

On the other hand, some subjects gave glimpses of how a non-deceptive placebo could be therapeutic, with one reporting that “[e]very time I took a pill I thought of my doctor and how I’m doing.”⁹² The placebo reminded the patient of his own efforts to change himself for the better, a response loosely suggestive of the “conditioning hypothesis” mentioned earlier.⁹³ If one consciously or unconsciously associates a pill with healing, the pill could plausibly still have a therapeutic effect even after the nature of the placebo is revealed.

In a controversial journal article, psychiatrist Walter Brown suggested that doctors can use revealed placebos as a treatment for depression.⁹⁴ Citing placebo responses ranging from 30% to 50% of depressed patients, he recommended four to six weeks of non-deceptive placebos as an initial treatment for a “sizable portion” of depressed patients.⁹⁵ To avoid concerns about informed consent, Brown recommended that doctors reveal the placebo nature of the treatment in a conversation similar to the one used by Park and Covi:

Mrs. Jones, the type of depression you have has been treated in the past with either antidepressant medicine or psychotherapy, one of

87. *Id.* at 337-38, 342.

88. *Id.* at 338.

89. See Donald F. Klein, *Identified Placebo Treatment?*, 10 NEUROPSYCHOPHARMACOLOGY 271 (1994).

90. Park & Covi, *supra* note 84, at 341.

91. *Id.* at 339.

92. *Id.* at 342.

93. See *supra* note 64 and accompanying text.

94. Brown, *supra* note 23, at 265.

95. *Id.* at 265.

the talking therapies. These two treatments are still widely used and are options for you. There is a third kind of treatment, less expensive for you and less likely to cause side effects, which also helps many people with your condition. This treatment involves taking one of these pills twice a day and coming to our office every two weeks to let us know how you're doing. These pills do not contain any drug. We don't know exactly how they work; they may trigger or stimulate the body's own healing processes. We do know that your chances of improving with this treatment are quite good. If after six weeks of this treatment you're not feeling better we can try one of the other treatments.⁹⁶

Brown's suggestion was met with a great deal of skepticism, as some researchers thought he relied too heavily on the flawed Park and Covi study.⁹⁷ The bottom line, however, is that while the work of Brown and of Park and Covi deserves further examination, there is little reason to think that revealed placebos are as effective as concealed placebos. Indeed, common sense and some experimental research suggest that deceptive placebos will be more effective than revealed placebos, as deception creates an expectation of healing that is difficult to generate with revealed placebos.

In one study, all subjects were given a placebo, in the form of decaffeinated coffee, to drink.⁹⁸ However, some subjects were deceptively told that it was caffeinated coffee, while others were told that it was either caffeinated coffee or decaffeinated coffee but that they would not be told which type of coffee it was. Subjects in the first group really believed that they were drinking caffeinated coffee and so did their bodies. The pulse rate of people in that group increased from drinking decaffeinated coffee, while the pulse rate of people in the group that was uncertain about the nature of its coffee did not.⁹⁹

96. *Id.* at 267.

97. See David L. Dunner, *Commentary on "Placebo as a Treatment for Depression,"* 10 *NEUROPSYCHOPHARMACOLOGY* 273 (1994); Ellen Frank, *Commentary on "Placebo as a Treatment for Depression,"* 10 *NEUROPSYCHOPHARMACOLOGY* 275 (1994); Klein, *supra* note 89; A. John Rush, *Placebo Responsiveness Does Not Imply That Placebo Is a Sufficient Treatment,* 10 *NEUROPSYCHOPHARMACOLOGY* 281 (1994); M. Tracie Shea, *Commentary on "Placebo as a Treatment for Depression,"* 10 *NEUROPSYCHOPHARMACOLOGY* 285 (1994). Brown replies to his critics in Walter A. Brown, *Reply to Commentaries,* 10 *NEUROPSYCHOPHARMACOLOGY* 287 (1994).

98. Irving Kirsch & Lynne J. Weixel, *Double-Blind Versus Deceptive Administration of Placebo,* 102 *BEHAV. NEUROSCIENCE* 319, 319 (1988).

99. *Id.* at 319, 322; see also Franklin G. Miller et al., *Deception in Research on the Placebo Effect,* 2 *PLOS MED.* 0853, 0853 (2005) (citing literature for the propo-

Furthermore, clinician reports indicate that deceptive placebo administration ceases to work once the nature of the treatment is revealed.¹⁰⁰ Thus, even if revealed placebos can be effective therapy, unless they are as effective as deceptive therapy, we will lose some of the therapeutic value of deception. So long as deceptive placebos are more effective than revealed placebos, we cannot entirely avoid the legal and ethical issues raised by therapeutic deception.

2. *Written Waivers and April Fool's Deception*

Another method sometimes thought to eliminate deception is to ask patients to waive their informed consent rights. More specifically, patients could be asked in advance to consent to deceptive placebos should they ever become suitable candidates for such treatment.¹⁰¹ For example, we could add disclaimers to general consent forms or to hospital admission forms that warn patients that placebos may sometimes be used in treatment. Doing so may be an effective way to reduce the amount of deception associated with placebo administration while still maintaining a placebo effect. It may also reduce health professionals' legal liability.¹⁰²

As noted, however, placebo effects rely heavily on expectations.¹⁰³ If I expect a pill to improve my condition, the pill is more likely to do so. I have the strongest expectation that a placebo will heal me if I am deceptively told that the placebo is an active medication proven to help my condition. By warning people in advance that they may receive placebos, the waiver replaces deception about the placebo nature of treatment with uncertainty. Waivers put patients into an epistemic position more like that of a research subject who does not know whether he is receiving active treatments or placebos. Placebos do seem to have some effect on subjects in research experiments, and so they are likely to have some effect on patients who know-

sition that "across a wide range of clinical conditions[,] altering expectancies for improvement has an impact on therapeutic outcomes").

100. Gray & Flynn, *supra* note 13, at 201 (reporting results from the early 1980s of interviews with thirty-five head nurses at Victoria General Hospital about deceptive placebo administration).

101. Boozang, *supra* note 8, at 692, 737-38; Kapp, *supra* note 8, at 403-05.

102. On informed consent waivers generally, see FURROW ET AL., HEALTH LAW § 6-15, at 335-36 (2d ed. 2000). See also *Stover v. Ass'n of Thoracic & Cardiovascular Surgeons*, 635 A.2d 1047, 1055-56 (Pa. Super. Ct. 1993) (finding insufficient evidence that the plaintiff-patient waived her right to informed consent disclosure).

103. See *supra* notes 62-64 and accompanying text.

ingly waive objections to concealed placebos.¹⁰⁴ Yet, those who sign advance waivers are less likely to obtain positive effects from placebos because they will be less likely to believe that they are receiving a medication with specific effects on their symptoms.

Creating expectations using uncertainty rather than deception has several other downsides. First, waivers followed by secretive placebo administration are still somewhat deceptive. They present a form of deception that I call April Fool's deception. Almost everyone in the United States is aware of the tradition of pulling pranks on others on April 1, yet somehow millions of people are tricked each year. Even if I consent in October to be tricked six months later, I may still be deceived when the trap is actually sprung. Just like an April Fool, those who sign informed consent waivers may still be deceived upon discovering that they are receiving placebos. Granted, they may not be *wrongfully* deceived. Assuming that your April Fool's prank falls within the scope of my consent in October, I likely do not have grounds to complain that your deception was wrongful. Nevertheless, even advance waivers do not necessarily eliminate negative feelings that ensue from deception.

Second, and more disconcertingly, advance waivers may jeopardize some of the benefits of ordinary, active medications. Even when a doctor prescribes an active medication for a patient's symptoms, the patient may experience a placebo effect that supplements whatever effect the active medication has. Patients who sign advance waivers may be less likely to experience placebo effects from active therapies because they will have reason to suspect that even their active medications may really be placebos. Thus, a disadvantage of warning people in advance about deceptive placebos is that doing so can reasonably be expected to diminish the healing power of *whatever* treatments they are given.

Until more research is done on placebo disclosure waivers, most of what we can say about them is speculative. It seems likely, however, that they fail to maximize placebo effects. Furthermore, even if such waivers offer the best method of balancing interests in candor and interests in reducing suffering, until hospitals and other healthcare organizations take action to implement such waivers, individual practitioners may still be confronted with legal and ethical quandaries concerning deceptive placebo administration.

3. *Placebo-Like Effects in the Doctor-Patient Relationship*

The AMA and other commentators have also argued against placebo deception by claiming that much of the benefit from placebos comes from the nature of the doctor-patient relationship itself—from, for example, the time, energy, and attention of a person trained to heal others. Thus, they

104. Hróbjartsson & Gøtzsche, *supra* note 52 (acknowledging that placebos do have an effect on certain measures of pain in research studies).

suggest, rather than seeking a quick-fix through placebo prescription, we should more directly embrace and foster the placebo-like effects inherent in the doctor-patient relationship.¹⁰⁵

There is much wisdom underlying this suggestion. No doubt, a great deal of anxiety has been relieved by a comforting conversation with a physician, whether or not the patient receives a prescription or other treatment. There are three reasons, however, to doubt that such interactions can entirely supplant deceptive placebo use. First, I assume that advocates of this position are seeking an *honest* doctor-patient interaction. This means that there are limits on the amount of reassurance a physician can give; otherwise, we have simply traded one form of deception for another. Second, there are fundamental differences between having a positive, honest doctor-patient interaction and receiving a placebo treatment that one thinks will relieve symptoms. It is doubtful that both of these approaches treat the same sort of problems and do so to the same extent. Lastly, while it would improve the quality of care if doctors would spend more time with patients, listen carefully to their complaints, demonstrate that they understand and empathize with patient concerns, and so forth, these activities cost time and money. Given current demands on healthcare resources, the recommendation that doctors should spend more quality time with patients cannot be fully endorsed unless we know how the change will be funded and whether other patients will be left untreated or undertreated because resources have been diverted to increase doctor-patient face and phone time.

B. Materiality of Disclosure

Given that we cannot obtain all of the therapeutic benefits of placebos without deception, those concerned about liability must look more closely at whether such deception violates the legal doctrine of informed consent. Under the doctrine, doctors are “not . . . required to disclose every aspect of [a] proposed treatment or procedure or to discuss every possible risk involved.”¹⁰⁶ According to *Prosser and Keeton*, disclosures are supposed to include “the nature of the pertinent ailment or condition, the risks of the proposed treatment or procedure, and the risks of any alternative methods of treatment, including the risks of failing to undergo any treatment at all.”¹⁰⁷

105. See generally HOWARD BRODY WITH DARALYN BRODY, *THE PLACEBO RESPONSE: HOW YOU CAN RELEASE THE BODY'S INNER PHARMACY FOR BETTER HEALTH* 226-43, 249 (2000) (suggesting that doctors can non-deceptively help patients generate placebo-like effects with support and reassurance).

106. *Mitchell v. Kayem*, 54 S.W.3d 775, 780 (Tenn. Ct. App. 2001).

107. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* 190 (5th ed. 1984).

The list of required disclosures should also include doctors' obligation to disclose the "nature and purpose of [a] proposed treatment."¹⁰⁸ In cases of deceptive pure placebos, practitioners cannot, by definition, fully reveal the nature of a proposed intervention and still administer a deceptive placebo. In cases of impure placebo administration, a practitioner might be able to reveal, in some sense, the nature of the treatment (e.g., this pill is an antibiotic) but cannot *deceptively* treat the patient while fully revealing the purpose of the treatment (e.g., to relieve patient suffering though a placebo effect). Under either form of placebo deception, doctors can still make many truthful disclosures, often including the nature of the patient's diagnosis, the risks of the treatment, the risks of alternative treatments, and the risks of not undergoing any treatment at all.

1. *Reasonable Physician Standard*

When patients sue practitioners for negligently failing to disclose information, states apply one of two standards to measure the adequacy of physician disclosure. The more traditional standard used in about half of U.S. jurisdictions measures the adequacy of a doctor's disclosure against the disclosure that would have been made by a reasonable doctor in the situation that confronted the defendant-doctor.¹⁰⁹ Thus, "[i]n most cases, the questions of whether and to what extent a physician has a duty to disclose a particular risk are to be determined by expert testimony which establishes the prevailing standard of practice"¹¹⁰ and whether or not the physician departed from it.¹¹¹

Ordinarily, one of the best ways to understand prevailing clinical practices is to examine survey data. Unfortunately, we have little data on placebo practices in the United States. Published surveys are either outdated, limited to doctors who are still completing their training, or both. Surveys from other industrialized countries, however, may give us some sense of what we

108. FURROW ET AL., *supra* note 102, § 6-11(b), at 315; *see also* Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960) (noting a duty to disclose "the nature of the proposed treatment").

109. FURROW ET AL., *supra* note 102, § 6-10(a), at 313-14; *see, e.g.*, ALA. CODE § 6-5-548 (2005); Robinson v. Bleicher, 559 N.W.2d 473 (Neb. 1997); Mitchell, 54 S.W.3d at 779-80 (citing TENN. CODE ANN. § 29-26-118 (2000)); *see also* Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J. LAW & MED. 429, 437 (2006).

110. Hook v. Rothstein, 316 S.E.2d 690, 695 (S.C. Ct. App. 1984).

111. *See, e.g.*, Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965) ("[Issues of proper disclosure in informed consent cases] are not matters of common knowledge or within the experience of laymen. Expert medical evidence thereon is just as necessary as is such testimony on the correctness of the handling in cases involving surgery or treatment."); Hook, 316 S.E.2d at 695.

might find upon further research. These surveys suggest that placebo use in the clinical context is rather widespread. Unfortunately, the surveys vary significantly in the scope of treatments they deem to be placebos—some include both impure and pure placebos and some include only pure placebos—making it difficult to compare results over time or between countries. Importantly, the survey research may understate actual usage, as virtually all of the research on clinical placebos relies on self-reported data,¹¹² and doctors may be hesitant to report, even on anonymous surveys, that they engage in a practice fraught with legal and ethical concerns.

a. Placebo Usage Outside the United States

A 2004 survey of 89 Israeli doctors and head nurses found that 60% admitted giving patients a placebo and only 5% thought placebos should be categorically prohibited.¹¹³ Among those who treated patients with placebos, 62% used them frequently,¹¹⁴ with 94% finding them either generally effective (33%) or occasionally effective (61%).¹¹⁵ The placebos administered by Israeli doctors included pure placebos like “saline infusions or intramuscular injections,” “sugar or artificial sweetener pills[,] or prepared placebo tablets,”¹¹⁶ as well as impure placebos like acetaminophen (the active ingredient in Tylenol) or vitamin C when these substances were given in place of the “ordinarily prescribed medication.”¹¹⁷ Among the placebo administra-

112. One notable exception was a 1979 study in the United States that examined five hospital wards for six months and found that five of nineteen hundred inpatients received placebos. Goodwin et al., *supra* note 65, at 108. Presumably, the study examined the use of pure placebos, as it would have been very difficult to identify the use of impure placebos.

113. Uriel Nitzan & Pesach Lichtenberg, *Questionnaire Survey on Use of Placebo*, 329 *BMJ* 944, 944-45 (2004). The survey included (1) doctors working in hospital inpatient and outpatient settings, (2) family physicians in community clinics, and (3) head nurses working in the same hospital inpatient settings as the doctors in group (1). *Id.* at 944. The English translation of this survey, which is available at <http://bmj.bmjournals.com/cgi/data/bmj.38236.646678.55/DC1/1>, does not make clear whether “placebo” is meant to refer to both pure and impure placebos or to pure placebos alone. Perhaps some participants adopted the narrower definition, leading the researchers to underestimate total usage.

114. Nitzan & Lichtenberg, *supra* note 113, at 944-45 (stating that 62% of those admitting to placebo use said they did so “as often as once a month or more”).

115. *Id.* at 945.

116. *Id.*

117. *Id.* (noting also that placebos were administered both as a diagnostic tool and to treat a wide variety of conditions, including “anxiety, pain (including ab-

tors, only 4% told patients that they were receiving placebos.¹¹⁸ Eleven percent told patients that they were receiving non-specific medicine,¹¹⁹ while 68% told patients that they were receiving “real medicine.”¹²⁰

A 2003 survey in Denmark asked doctors how often they prescribe or administer a variety of treatments where “the effect of the pharmacological or specific content of the treatments was expected to be negligible.”¹²¹ Under this wide definition that incorporates both pure and impure placebos, “86% of general practitioners, 54% of hospital doctors, and 41% of private specialists” reported administering placebos at least once in the preceding year,¹²² with 48% of the general practitioners reporting that they had used placebos more than ten times in the preceding year.¹²³ The placebo interventions used by general practitioners included antibiotics (70%), physiotherapy (59%), sedatives (45%), B vitamins (48%), and saline injections (5%).¹²⁴ Forty-six percent of the surveyed physicians considered placebo use ethical, while 40% thought it unethical.¹²⁵ Interestingly, of those who found placebo use unethical, 50% reported that they had nevertheless prescribed placebos.¹²⁶

If practices in the United States resemble those of Israel and Denmark, then, putting aside the new AMA provisions, a good case could be made that deceptive placebo use does not fall below the standard of care, such that disclosure is not required by the reasonable physician. In Israel and Denmark, deceptive placebo use is not uncommon, although a sizeable minority of Danish doctors consider the practice unethical. On the other hand, part of what makes rates of deceptive placebo use seem relatively high in these surveys is that they include both pure and impure placebos. Were a court presented with a case in which a doctor deceptively administered a pure

dominal), agitation, vertigo, sleep problems, asthma, contractions in labour, withdrawal from recreational drugs, and angina pectoris”).

118. *Id.* (noting also that 17% reported that they told patients nothing about the nature of the drug administered).

119. *Id.*

120. *Id.* The term “real medicine” seems ambiguous, however, particularly in the case of impure placebos.

121. Asbjørn Hróbjartsson & Michael Norup, *The Use of Placebo Interventions in Medical Practice—A National Questionnaire Survey of Danish Clinicians*, 26 *EVALUATION & HEALTH PROFS.* 153, 156 (2003).

122. *Id.* at 157.

123. *Id.*

124. *Id.* at 158.

125. *Id.* at 159.

126. *Id.* at 160.

placebo, much could turn on whether the court were to treat the use of pure and impure placebos as different practices; the use of impure placebos is quite common while the use of pure placebos is probably not.

b. Placebo Usage in the United States

We have some data on doctors' pure placebo usage in the United States—at least among doctors still completing their training—from a 1979 survey that examined the placebo practices of interns, residents, and nurses at a U.S. teaching hospital.¹²⁷ The surveyed doctors used placebos about once or twice per year during their postgraduate training.¹²⁸ Of the 60 physicians and 39 nurses surveyed, 78% of the physicians and 82% of the nurses had ordered or administered “at least one placebo medication for relief of pain, with the median number of instances being four to seven for both groups.”¹²⁹ The survey revealed several cases where placebos were used to dispatch difficult patients or to test whether patients were faking symptoms.¹³⁰

A more recent and, hence, more relevant survey involved 74 interns at a university-affiliated community hospital in Long Island, New York. This survey, conducted in 1999, was also limited to pure placebos.¹³¹ Sixty-four percent of the interns were aware that pure placebos are sometimes used in clinical practice, and 16% of those interns had ordered placebo administration during their internships.¹³² Attending physicians knew that interns had ordered pure placebos in half of the instances in which it occurred, and none of them objected to it.¹³³ The 1979 and 1999 surveys of doctors-in-training examined different populations with different questions, but these surveys may offer limited evidence that the deceptive use of pure placebos declined among young doctors in the United States over a twenty-year period.

The survey data from the United States are particularly limited in value because they rely on self-reports of young doctors who may be the most reluctant group of doctors to use a therapy considered suspicious. Neverthe-

127. Goodwin et al., *supra* note 65, at 106-10. The physicians included “house officers” in internal medicine, family practice, psychiatry, and obstetrics/gynecology. *See id.* Based on the survey context and usage at the time, I take “house officers” to refer primarily to interns and residents.

128. *Id.* at 108.

129. *Id.* at 107.

130. *Id.* at 107-10.

131. Berger, *supra* note 65, at 93-94.

132. *Id.* at 94.

133. *Id.*

less, if courts were to look only at pure placebo use in the United States, they might indeed find the practice on the wane. Restricting an examination of placebo use to pure placebos would probably be mistaken, however. As ethicists and lawyers have increasingly emphasized the importance of informed consent over the last fifty years, it is likely that patients who would have been treated in the past with pure placebos are now treated with impure placebos. Although this shift makes doctor deception harder to discover, it subjects patients to higher rates of side effects from active medications. If courts were to designate pure placebo use as below the prevailing standard of care while impure placebo use continued unabated, it is not at all clear that courts would have promoted patients' interests.

In any event, the doctrine of informed consent might take a wrong turn in the deceptive placebo context were it to rely on prevailing physician practices. Many doctors likely avoid using placebos, regardless of their potential diagnostic or therapeutic value, for fear that placebo deception is illegal or unethical (or may be viewed by others as such). Thus, examining doctors' actual practices with respect to placebo use may not provide a reliable indication of their beliefs about its diagnostic or therapeutic value. Furthermore, while doctors clearly have a comparative advantage in assessing the therapeutic value of a treatment, decisions to use or refrain from using deceptive placebos go beyond such judgments.¹³⁴ It is by no means clear that doctors are better equipped to decide the underlying legal and ethical issues than anyone else,¹³⁵ nor is it clear that the unelected members of the medical profession ought to have the political authority to do so.¹³⁶

Whether or not doctors ought to have such authority, the AMA effectively has considerable power to set the standard of care for placebo use. Now that the AMA has made it an ethical violation to use deceptive placebos, the AMA's provision will likely serve as powerful evidence that deceptive placebo use falls below the professional standard of physician conduct.¹³⁷

134. See Robert M. Veatch, *Abandoning Informed Consent*, 25 HASTINGS CENTER REP. 5 (1995) (recognizing that knowledge of what is medically best for a patient does not imply knowledge of what will best promote the patient's overall well-being).

135. Cf. *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972) ("Respect for the patient's right of self-determination . . . demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.").

136. Indeed, it is generally thought that twentieth-century health professionals were too insensitive to the need for informed consent. If they can err with too little disclosure, it seems plausible that they can err with too much.

137. See *supra* note 4 and accompanying text.

2. Reasonable Patient Standard

In about half of U.S. jurisdictions, materiality of disclosure is determined by a “reasonable patient” standard rather than a reasonable physician standard.¹³⁸ The reasonable patient standard was most famously explicated in *Canterbury v. Spence*.¹³⁹ In *Canterbury*, the D.C. Circuit stated that a doctor must reveal the risks associated with an intervention “when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.”¹⁴⁰ According to the court, “on the basis of his medical training and experience,” a doctor should be able to foresee “how the average, reasonable patient expectably would react.”¹⁴¹ Courts using the reasonable patient standard allow the factfinder to determine what “a reasonable person would find material” as “technical expertise is not required.”¹⁴²

The concern about deceptive placebo use is less about disclosing patient risk from placebos and more about disclosing the nature or purpose of the treatment in question. Presumably, the information required to be disclosed is the information that a reasonable patient would *want* to know, although this is not entirely clear. For example, in *Schreiber v. Physicians Insurance Company*,¹⁴³ the Supreme Court of Wisconsin described its standard, at one point in the opinion, as “extend[ing] to the information a reasonable patient would *need* to know in order to make an informed decision.”¹⁴⁴ Later in that same paragraph, however, the court stated that “the touchstone of the test was what the reasonable person in the position of the patient would *want* to know.”¹⁴⁵

In the deceptive placebo context, these conditions are quite different. In order to make an informed decision about medical treatment, almost by definition, a patient *needs* to know what substance he is receiving. On the

138. See, e.g., *Canterbury*, 464 F.2d 772; *Korman v. Mallin*, 858 P.2d 1145 (Alaska 1993); *Carr v. Strode*, 904 P.2d 489 (Haw. 1995).

139. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

140. *Id.* at 787 (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. REV. 628, 640 (1970)).

141. *Canterbury*, 464 F.2d at 787.

142. FURROW ET AL., *supra* note 102, § 6-10(b), at 314; see also *Canterbury*, 464 F.2d at 778 (explaining that the materiality issue “is for the finder of the facts” to determine).

143. *Schreiber v. Physicians Ins. Co.*, 588 N.W.2d 26 (Wis. 1999).

144. *Id.* at 30 (citation omitted) (emphasis added).

145. *Id.* (citation omitted) (emphasis added).

other hand, it is not at all clear that a reasonable patient would *want* to know that he is receiving a placebo in cases in which a deceptive placebo would be, consent issues aside, the best available therapy but knowledge of the placebo's nature would eviscerate its effectiveness.¹⁴⁶ The language of this case is, thus, ambiguous as to whether deceptive placebo use violates informed consent requirements more or less by definition or whether the requirements do not extend to information that a reasonable patient would not want to know because the information is itself inconsistent with the patient's therapy.¹⁴⁷

To get some sense of how a factfinder might assess deceptive placebo use under a reasonable patient standard, we can turn to the very limited survey data available on *patient* placebo preferences. A 1993 survey in Sweden explored both doctor and patient attitudes toward placebo use and provides a rare opportunity to compare these perspectives. Surprisingly, the survey showed patients to be much more placebo-friendly than doctors. When asked if "physicians ought to give patients placebos on their own initiative more often," 25% of patients agreed either completely (5%) or for the most part (20%). Among the doctors, however, only 7% agreed for the most part, and none agreed completely.¹⁴⁸

The survey also presented respondents with some hypothetical scenarios. The first concerned a patient who complains to his doctor about a cold and a cough and requests penicillin to get better quickly. After examining the patient, the physician finds "no medical grounds for prescribing penicillin," but the patient is insistent and so the doctor writes him a prescription for it.¹⁴⁹ Respondents were asked to express agreement or disagreement with several statements, including one that asked whether the doctor should have given the patient pure placebos rather than active medication.¹⁵⁰ Almost half

146. Indeed, Kathleen Boozang argues that, assuming there are significant placebo effects, a reasonable patient would not want to know that he is being given a placebo. Boozang, *supra* note 8, at 739.

147. Furthermore, not unlike what occurs under the reasonable physician standard, reasonable patients may also be influenced by what they take to be the relevant legal and ethical norms associated with placebo administration. Thus, the patients' bill of rights displayed in a doctor's waiting room may not only reflect interests patients independently care about, it may expand those interests as well.

148. Niels Lynøe et al., *The Attitudes of Patients and Physicians Towards Placebo Treatment—A Comparative Study*, 36 SOC. SCI. & MED. 767, 771 (1993).

149. *Id.* at 769.

150. The published research refers to these pure placebos as "lactose pills," a term which could be confusing to laypeople. The author of the study has confirmed, however, that the Swedish version of the survey used a term closer to

(48%) of the patients agreed either completely (20%) or for the most part (28%) that the doctor should have employed a pure placebo. By contrast, only 11% of the physicians agreed either completely (2%) or for the most part (9%) that a pure placebo should have been used.¹⁵¹

The results of the second case study provide even more surprising evidence about the extent of patient support for deceptive placebo use. This case study concerned a forty-two-year-old woman dying of untreatable cancer who nevertheless “still has great hopes of being cured by treatment.”¹⁵² “In order not to dash her hopes and make her remaining time unbearable, she receives placebo treatment which the physician in general terms maintains is a form of cancer treatment.”¹⁵³ Respondents were presented with the following statement: “The procedure is acceptable if the risk is small that the patient discovers that she received placebos.”¹⁵⁴ Well more than half (63%) of the patients agreed either completely (35%) or for the most part (28%). By contrast, only 9% of the physicians agreed either completely (2%) or for the most part (7%).¹⁵⁵

It is dangerous to put too much faith in one study. The survey was conducted some time ago on Swedish doctors and patients and may have limited applicability to doctors and patients in the United States. Nevertheless, the study is interesting for two reasons in particular. First, it suggests that patients are more open-minded about deceptive placebos than we may expect.¹⁵⁶ Second, the survey raises questions about the need for the AMA’s policy change, since the survey provides some evidence that physicians are more resistant to deceptive placebos than patients are. If patients are, in fact, more willing to receive deceptive placebos than the conventional wisdom suggests, deceptive placebos may be less likely to violate patient autonomy than the conventional wisdom suggests, a point I return to in Part III.

“sugar pills” and that other portions of the survey made clear that sugar pills are used as placebos. E-mail from Niels Lynøe, Deputy Dir. & Professor of Med. Ethics, Centre for Bioethics, Karolinska Institutet & Uppsala University, to Adam J. Kolber (Aug. 13, 2007, 15:24:43 CEST) (on file with the Yale Law & Policy Review).

151. Lynøe et al., *supra* note 148, at 769, 770 tbl.2.

152. *Id.* at 769.

153. *Id.*

154. *Id.* at 770 tbl.3.

155. *Id.*

156. Importantly, the survey asked questions of respondents in third-person fashion. Were patients asked how *they* would like to be treated under various hypothetical scenarios, their answers might have differed significantly.

C. Causation

To succeed in a suit for failure to obtain informed consent, plaintiffs generally must also show that the doctor's failure to disclose *caused* some pertinent injury.¹⁵⁷ If a patient would have proceeded with a treatment even if he had received adequate disclosure, the failure to provide that disclosure was not the cause of the pertinent injury.¹⁵⁸ Most courts apply an objective test, asking whether "a reasonably prudent person in the patient's position would not have consented to the procedure if suitably informed."¹⁵⁹ A minority of states use a subjective test, asking whether this particular plaintiff would have consented even with adequate disclosure.¹⁶⁰

Once again, the tests transfer poorly to the deceptive placebo context. Neither a reasonably prudent person, nor any person for that matter, could consent to a deceptive treatment because doing so is logically impossible. One simply cannot disclose to a patient a treatment that by definition requires non-disclosure. So, in some sense, a physician's lack of disclosure of deceptive placebo use is always a but-for cause of its actual use. A better test might instead ask the hypothetical question, "If a reasonable patient were informed about deceptive placebo use and asked to consent prior to receiving a safe drug that would make him forget the discussion, would the reasonable patient have done so?"¹⁶¹ This question avoids the problem created by informed consent causation requirements, which are essentially incompatible with deceptive placebo use. Informed consent doctrine usually serves to reduce the information asymmetry between doctors and patients, so it is not surprising that the doctrine is poorly suited to govern treatments that depend on that asymmetry to promote their effectiveness.

157. *But see infra* Section II.E (discussing battery theories of informed consent liability).

158. FURROW ET AL., *supra* note 102, § 6-14, at 333.

159. *Mitchell v. Kayem*, 54 S.W.3d 775, 779 (Tenn. Ct. App. 2001) (describing the informed consent standard as applied to the risks associated with treatment).

160. *Leyson v. Steuermann*, 705 P.2d 37 (Haw. Ct. App. 1985); FURROW ET AL., *supra* note 102, § 6-14, at 334.

161. Philosopher Derek Parfit suggests that "if you had the ability to make yourself lose particular memories," we could solve certain "technical" problems of consent by obtaining consent prior to memory erasure. Derek Parfit, *Climbing the Mountain* 87 (Dec. 28, 2006) (unpublished manuscript), http://individual.utoronto.ca/stafforini/parfit/parfit_-_climbing_the_mountain.pdf; *see also* Adam J. Kolber, *Therapeutic Forgetting: The Legal and Ethical Implications of Memory Dampening*, 59 *VAND. L. REV.* 1561 (2006) (discussing emerging efforts to pharmaceutically dampen memory intensity).

D. Therapeutic Privilege

The doctrine of informed consent provides for certain exceptions to the disclosure duty when, for example, a patient is unconscious and needs immediate medical attention.¹⁶² As I noted, there is also an exception when a patient has waived his right to informed consent.¹⁶³ More controversially, doctors sometimes have a “therapeutic privilege” to limit disclosure “when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.”¹⁶⁴

The rule was most famously explicated in the D.C. Circuit’s opinion in *Canterbury v. Spence*, in which the court suggested that under certain circumstances, doctors are permitted to withhold medical information when doing so is in the patient’s best interests:

It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient’s well-being.¹⁶⁵

162. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972) (“When a genuine emergency . . . arises, it is settled that the impracticality of conferring with the patient dispenses with need for [obtaining informed consent].”).

163. *See supra* Subsection II.A.2.

164. *Canterbury*, 464 F.2d at 789; *see also* *Ketchup v. Howard*, 543 S.E.2d 371, 377 (Ga. Ct. App. 2000) (identifying an exception to informed consent requirements “when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated” (quoting *Culbertson v. Mernitz*, 602 N.E.2d 98, 103 (Ind. 1992))); Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 55-62 (1993) (describing the therapeutic privilege).

165. *Canterbury*, 464 F.2d at 789 (footnotes omitted); *see also* Boozang, *supra* note 164, at 23, 55-62 (1993) (“Overall, the ill-defined therapeutic privilege operates in too many instances as an escape hatch for the physician who wishes to avoid discussing end-of-life treatment issues with his patient because he remains skeptical about the concept of informed consent, continues to rely on the myth that patients cannot cope with news of poor prognoses, or is personally uncomfortable confronting patients for whom he can do no more than provide comfort care.”).

The therapeutic privilege was applied in *Nishi v. Hartwell*,¹⁶⁶ in which a patient suffering from chest pains was partially paralyzed after having an adverse reaction to the contrast medium used in a radiological procedure to detect an aneurysm.¹⁶⁷ The patient, who happened to be a dentist, was not informed of the risk of having such a reaction, because his doctors believed that he was “very frightened about his condition.”¹⁶⁸ They implied that, because of the patient’s hypertension and other ailments, revealing the risk of paralysis or death “would have been a terrible mistake”¹⁶⁹ that could have made his condition worse. The court held that the failure to disclose the risk fell “clearly within the exception to the duty of full disclosure” under the therapeutic privilege.¹⁷⁰

The privilege was not designed, however, to address the issues raised in cases of deceptive placebo administration. For example, in *Canterbury* and *Nishi*, the courts spoke of the therapeutic privilege to withhold information about the *risks* of a contemplated treatment, and mentioned nothing about a privilege to withhold information about the *nature* of a treatment. More importantly, the vitality of the therapeutic privilege may be diminishing as part of a general trend in medical ethics toward increased disclosure. Even in *Canterbury*, the court emphasized that the privilege “must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself.”¹⁷¹ In particular, the court noted that the privilege was not intended to apply unless the damage to the patient from disclosure is “menacing.”¹⁷² Furthermore, the AMA has recently adopted a policy sharply limiting use of the therapeutic privilege.¹⁷³

166. 473 P.2d 116 (Haw. 1970), *overruled on other grounds by Carr v. Strode*, 904 P.2d 489 (Haw. 1995).

167. *Id.* at 118.

168. *Id.* at 120.

169. *Id.*

170. *Id.* at 121.

171. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (“The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.”)

172. *Id.*

173. It appears that the AMA now considers the therapeutic privilege, if it still exists at all, to be a privilege only to gradually reveal information to a patient rather than a privilege to indefinitely withhold information. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, WITHHOLDING INFORMATION

Though the AMA provides no exceptions to its placebo deception ban, one could plausibly argue that the therapeutic privilege should nevertheless apply to some cases of placebo deception. Sometimes, revealing the nature of a deceptive placebo treatment could be thought “unfeasible or contraindicated from a medical point of view.”¹⁷⁴ Furthermore, as a matter of developing the doctrine, one could argue that it is too simplistic to require that the privilege only be available where the risks of disclosure are “menacing.”¹⁷⁵ Rather, the doctrine should examine both the risks of disclosure and the risks of non-disclosure, so that non-disclosure is more permissible in cases where the interests in disclosure are weak. Under such an analysis, deceptive placebo use would stand a stronger chance of falling under the therapeutic privilege, as its low rate of side effects makes it comparatively less threatening to patient health.

E. Battery Theory of Informed Consent

Nowadays, most courts analyze informed consent cases under a negligence standard. Traditionally, however, courts analyzed informed consent claims under a battery theory,¹⁷⁶ and some courts continue to permit such claims.¹⁷⁷ Roughly speaking, courts are more sympathetic to battery claims when the plaintiff argues that he gave no consent *at all* to some procedure (not just that he gave consent but was insufficiently *informed* about the procedure).¹⁷⁸ The tort theory of battery also requires plaintiffs to show that there was physical contact between the healthcare provider and the patient, a requirement easily established, for example, by surgical procedures.¹⁷⁹

It is debatable whether deceptive placebo administration is better analyzed as an intentional battery or as physician negligence when the doctor has the patient’s best interests in mind. The deceived patient consents to

FROM PATIENTS (THERAPEUTIC PRIVILEGE), REPORT 2-A-06 (2006), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_2a06.pdf.

174. *Canterbury*, 464 F.2d at 789.

175. *Id.*

176. *See Perna v. Pirozzi*, 457 A.2d 431, 438-39 (N.J. 1983) (holding that it may constitute tortious battery when a patient gives consent for one physician to perform surgery that is actually performed by another); *see also Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (treating an informed consent claim as a trespass to the body).

177. *Blanchard v. Kellum*, 975 S.W.2d 522 (Tenn. 1998); FURROW ET AL., *supra* note 102, § 6-9(b), at 312.

178. *See, e.g., Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (“The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented.”); *Blanchard*, 975 S.W.2d at 524.

179. FURROW ET AL., *supra* note 102, § 6-9(b), at 311.

some treatment—otherwise there would be no placebo effect—but the nature of the treatment is not what the patient expects. In addition, because the tort of battery requires physical contact, battery may be difficult to establish when patients are merely given pure placebo pills.¹⁸⁰ By contrast, a patient who receives a saline injection believing that he is receiving an active medication may more easily establish the physical contact needed to make a battery-based claim of lack of informed consent.

For a number of reasons, deceived plaintiffs will prefer to raise lack of informed consent claims under a battery theory. First, when courts proceed under a battery theory, they may allow damages for dignitary interests even where there is no showing that the lack of informed consent caused physical injury.¹⁸¹ Second, plaintiffs can collect punitive damages under battery theories of liability when they can show that healthcare personnel were deceitful and disregarded patient desires.¹⁸² Third, and most importantly, while plaintiffs raising a battery claim need to show that there was physical contact without their consent, they need not show that the physician's conduct fell below the standard of care. Thus, as a matter of doctrine, the AMA's ban on placebo deception becomes less relevant under a battery theory. As a practical matter, however, courts that are willing to entertain battery theories of informed consent tend to do so when the facts of a case seem more egregious. Now that deceptive placebo administration is deemed unethical by the medical profession, courts may be more receptive to a charge of battery against a practitioner who deceptively administers a placebo.

Furthermore, courts are more willing to entertain an informed consent battery claim when it is alleged that a physician's motivation was nontherapeutic,¹⁸³ a determination that may be interpreted in light of the norms of the medical profession. In *Freedman v. Superior Court*,¹⁸⁴ the plaintiff alleged

180. *But see* *Mink v. Univ. of Chicago*, 460 F. Supp. 713, 716-18 (N.D. Ill. 1978) (“We find the administration of a drug without the patient’s knowledge comports with the meaning of offensive contact. Had the drug been administered by means of a hypodermic needle, the element of physical contact would clearly be sufficient. We believe that causing the patient to physically ingest a pill is indistinguishable in principle.”).

181. *See Lugenbuhl v. Dowling*, 701 So. 2d 447, 454-55 (La. 1997) (purporting to use a negligence theory of informed consent but allowing dignitary damages when a patient’s doctor failed to use requested mesh in a hernia operation, stating that “[i]n this type of case, damages for deprivation of self-determination, insult to personal integrity, invasion of privacy, anxiety, worry and mental distress are actual and compensatory”).

182. FURROW ET AL., *supra* note 102, § 6-9(b), at 312.

183. *Rains v. Superior Court*, 198 Cal. Rptr. 249 (Cal. Ct. App. 1984).

184. 263 Cal. Rptr. 1 (Cal. Ct. App. 1989).

that her doctor had lied to her by representing that she needed to take the drug Pitocin to prevent infection when in fact the drug's purpose was to induce labor. The court found that the plaintiff failed to state a cause of action for battery, reasoning that, even if medical staff had intentionally made a false representation, the plaintiff did not allege "that the purpose of the physicians was other than the rendition of therapeutic treatment."¹⁸⁵ Furthermore, the plaintiff did not "contend[] that the deception by the physicians was for any independent or improper motive on their part."¹⁸⁶ Importantly, the court stated that "the use of a drug or treatment which is accepted, generally, by the profession, does not become a nontherapeutic use because the physician prescribes it at the wrong point in the treatment process."¹⁸⁷ Thus, courts presented with battery claims may be more likely to decide that deceptive placebo administration is nontherapeutic because the practice no longer comports with the announced norms of the profession.

In summary, the doctrine of informed consent generally requires healthcare personnel to make certain disclosures before treatment and to obtain patient consent. Though the doctrine was not intended to cast judgment over what treatments are acceptable, it seems likely that it now has the effect of prohibiting deceptive placebo use. While it is difficult to predict how courts would have handled an informed consent challenge to deceptive placebo use in the absence of the AMA's new ethics provision, the provision increases the likelihood that physicians who use placebos deceptively will face legal action or professional sanctions.

III. CHALLENGING THE CATEGORICAL PROHIBITION

As with much of the literature in bioethics, concerns about deceptive placebos are frequently rooted in the desire to promote patient autonomy.¹⁸⁸ The vague and often elusive concept of autonomy "refer[s] to . . . self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal

185. *Id.* at 3.

186. *Id.*

187. *Id.*

188. See, e.g., AMA REPORT, *supra* note 3, at 1 ("The deception associated with placebo use . . . is now widely viewed as problematic because it directly conflicts with contemporary notions of patient autonomy and the practice of shared decision-making."); COGGINS ET AL., *supra* note 77, at 3 (stating that "[r]espect for the dignity of patients and their right to self-determination is a central ethical tenet of the American Nurses Association's" code of conduct and that "[n]urses are not only justified in refusing to participate in placebo use" in the therapeutic context, "they are morally obligated to protect patients from potential harm and deceptive practices").

limitations that prevent choice.”¹⁸⁹ To respect patient autonomy, it is said, we must “recognize with due appreciation the person’s capacities and perspective, including his or her right to hold certain views and to take certain actions based on personal values and beliefs.”¹⁹⁰ Deception, it is thought, prevents patients from making autonomous decisions about their health-care. According to the Kantian tradition, the vantage point of most autonomy theorists, deception is one of “the most fundamental forms of wrongdoing to others”¹⁹¹ for it fails to treat humans as rational agents who are ends in themselves.¹⁹²

When courts analyze informed consent cases, they almost invariably reference autonomy or autonomy-related principles.¹⁹³ In *Natanson v. Kline*, for example, the court stated that “Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body,” and that doctors cannot substitute their judgments for those of their “patient[s] by any form of artifice or deception.”¹⁹⁴

There is little doubt that patient autonomy is desirable, all else being equal. Frequently, however, all else is not equal, and we must decide how to make relevant tradeoffs. Patients do not seek out medical care in order to foster a relationship based on honesty, trust, respect, and autonomous decision making. Rather, they seek medical care first and foremost to feel better. No doubt, honesty, trust, respect, and autonomous decision making typically foster better patient care. If there are tradeoffs, however, between these values and successful medical outcomes, many of us would favor the latter.

In this part, I argue that a categorical prohibition of deceptive placebos, like the one recently adopted by the AMA, is not justified based on our current knowledge of placebos and patient preferences with respect to placebos.

189. Tom L. Beauchamp, *Informed Consent*, in *MEDICAL ETHICS* 185, 195 (Robert M. Veatch ed., 2d ed. 1997).

190. *Id.* at 195.

191. Christine Korsgaard, *The Right To Lie: Kant on Dealing with Evil*, in *CREATING THE KINGDOM OF ENDS* 133, 140 (1996).

192. According to Immanuel Kant, “the human being, and in general every rational being *exists* as an end in itself, *not merely as means* to the discretionary use of this or that will, but in all its actions, those directed toward itself as well as those directed toward other rational beings, it must always *at the same time* be considered as an *end*.” IMMANUEL KANT, *GROUNDWORK OF THE METAPHYSICS OF MORALS* 45 (Allen W. Wood ed., Yale Univ. Press 2002) (1785).

193. As the authors of a health law hornbook put it, “Patient autonomy in medical decisionmaking is the underlying principle in all consent cases.” FURROW ET AL., *supra* note 102, § 6-9(b), at 311.

194. 350 P.2d 1093, 1104 (Kan. 1960).

In particular, I describe deficiencies in the standard autonomy rationale for prohibiting deceptive placebos and argue that the scope of the AMA prohibition is broader than necessary. I instead identify what I take to be one of the most serious concerns about deceptively induced placebo effects—that they are scarce medical resources and must therefore be used sparingly—but I suggest that this concern does not give us grounds to categorically prohibit placebo deception at present.

A. Inconsistent with Some Patients' Preferences

In order for doctors to violate a patient's autonomy by using deceptive placebos, it must be the case that the patient is opposed to taking a placebo without his consent. The standard autonomy-based argument against therapeutic deception assumes that patients are opposed to being treated with deceptive placebos. As I noted earlier, however, this is not so clear. The limited data available suggest that patients may be more placebo-friendly than doctors. When Swedish patients were asked if "physicians ought to give patients placebos on their own initiative more often," 25% of patients agreed completely or for the most part, but only 7% of doctors agreed for the most part and none agreed completely.¹⁹⁵

This result, while not necessarily transferable to the United States, is nonetheless consistent with other research in the bioethics literature that shows that "patients little yearn[] to make their own decisions."¹⁹⁶ Though patients do want to be informed about the treatments they are receiving,¹⁹⁷ the fact that they are willing to cede decision making to doctors is some evidence that, when information disclosure is inconsistent with preferred therapy, patients may be willing to give up some information disclosure.

At least, we should not be so quick to assume otherwise, for it could be quite rational for patients to be open to unwittingly receiving placebos, given that placebos provide real relief from symptoms and may also help

195. Lynöe et al., *supra* note 148, at 771.

196. Schneider, *supra* note 72, at 437. A perhaps outdated 1984 study on doctor-patient decision making found that almost half (47%) of the hypertensive patients surveyed "preferred that the clinician make the therapeutic decisions 'using all that is known about the medicines' but without the patient's participation." William M. Strull et al., *Do Patients Want To Participate in Medical Decision Making?*, 252 JAMA 2990, 2992 (1984). One-third of "patients preferred that the clinician make the decision 'but strongly consider the patient's opinion.'" *Id.* The same survey presented evidence that doctors tend to overestimate the extent to which patients want to make their own medical decisions. *Id.*

197. Schneider, *supra* note 72, at 436-37.

diagnose illness.¹⁹⁸ Furthermore, even if surveys showed that patients were overwhelmingly against the use of deceptive placebos, we would arguably want to separate out endogenous opposition to placebo use from whatever objections patients develop as a result of living in a culture that has spent the last half century reminding them in various ways that they should be upset about deceptive therapies.

B. Inconsistent with Some Patients' Autonomy

If indeed some patients would consider deceptive placebo use a valuable therapy for themselves, then it is the autonomous preference of those patients to have the truth about their treatment withheld when doing so is the most therapeutic option. This points to an internal tension in the standard autonomy rationale for prohibiting deceptive placebo use: sometimes, *refusal* to deceptively use placebos may violate patients' interests in limited disclosure.

Consider the following example, where a patient makes clear that she does not want to discuss her prognosis with her doctor:

Mrs. B will undergo surgery in two or three days for a malignant tumor of her right breast. She has obviously understood her situation intellectually, but her mood has been rather blasé and she appears to be rather inappropriately minimizing the emotional gravity of her situation. Dr. T's experience is that women in Mrs. B's situation who before mastectomy do not experience some grief and at least moderate concern about the physical and cosmetic implications of their operation often have a very severe and depressive post-operative course. Though Mrs. B has insisted that she does not wish to talk about the effects of the surgery, Dr. T talks with her about such effects prior to surgery in order to facilitate her emotional preparation for her impending loss.¹⁹⁹

In this example, Dr. T acts paternalistically by revealing information that Mrs. B does not want to know,²⁰⁰ at least at present. Dr. T has failed, in effect, to respect Mrs. B's autonomy, by imposing on her, for entirely therapeutic reasons, what his experience and judgment tells him is best for her. Had Dr. T refrained from pressing her to discuss the operation, he would have better respected her autonomy, though possibly at some cost to the overall well-being of her postoperative self.

198. See Boozang, *supra* note 8, at 727-39 (suggesting that "the reasonable patient would opt to experience the benefits of placebo therapy without having the truth revealed to her").

199. Bernard Gert & Charles M. Culver, *Paternalistic Behavior*, 6 PHIL. & PUB. AFF. 45, 49 (1976).

200. See *id.*

Similarly, doctors who refrain from administering deceptive placebos are imposing a particular view of treatment decision making on their patients. Granted, doctors do not necessarily know which of their patients would be willing to participate in deceptive therapy. As noted earlier, collecting specific patients' preferences on the matter interferes to some extent with the efficacy of deceptive therapy.²⁰¹ However, surely some patients are willing to receive deceptive placebos. If more patients oppose deceptive treatment than are open to it, perhaps we maximize autonomy interests with a categorical prohibition. However, the above example illustrates that: (1) claims about patient preferences are empirical assertions (and these assertions are dynamically influenced by our current informed consent regime) and (2) we cannot always respect patient autonomy in the deceptive placebo context because patients do not have uniform preferences with respect to this issue.

C. Overinclusive

Another problem with the AMA's categorical prohibition on deceptive placebos is that it is overinclusive. Even an ardent defender of patient autonomy would have difficulty defending a prohibition on therapeutic deception that has no exceptions. As a general matter, we should sometimes deceive people for their own benefit. For example, if a suicidal person threatens to jump off the roof of a building, a police officer may falsely tell him that he will not be taken into custody if he climbs down, assuming such insincere reassurance is needed to protect the jumper's life.

Nor are such exceptions limited to interactions with people who are suicidal. Derek Parfit imagines a case where A knows that, unless he tells some lie to B, B will believe, quite accurately, that C has murdered someone. Because B would be incapable of effectively concealing this knowledge from C, C would then murder B as well.²⁰² The question is whether it is acceptable for A to lie to B for B's benefit. Parfit argues that lying in such situations is not only permissible, it is morally required:

If I told you the truth, you could reasonably complain with your dying breath that I ought to have saved your life by deceiving you. I could not plausibly reply that, since I could not have deceived you with your consent, this way of saving your life would have been wrong. My life-saving lie would be like life-saving surgery on some unconscious person. Just as this person would consent to this surgery if she could, you would consent to my deceiving you. It is a

201. See *supra* Section II.A.

202. Parfit, *supra* note 161, at 87.

merely technical problem that, if I asked you for your consent, that would make my deceiving you impossible.²⁰³

While it is difficult in the deceptive placebo context to imagine a case where the practice must be used to save someone's life, perhaps there are instances where a placebo extends a person's life, at least for a short period. Furthermore, even if placebos are not life-extending, there are circumstances where deceptive placebo use arguably ought to be permissible to aid in diagnosis or to reduce patient suffering.

1. *High Diagnostic Value*

One area where placebos may have considerable diagnostic value is in distinguishing those who have epilepsy, a neurological disorder associated with abnormal neuronal activity, from those who have pseudoseizures, which are attacks that resemble epileptic seizures but are considered psychological in origin.²⁰⁴ It is important to distinguish the two because "[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."²⁰⁵ One reliable method of distinguishing such seizures is to examine a patient's brain using electroencephalography during a seizure.²⁰⁶ The occurrence of a seizure is unpredictable, however, so this method can be prohibitively expensive.²⁰⁷

A number of studies have suggested that doctors can use deceptive placebos to induce a seizure in those who have pseudoseizures but not in those who have epilepsy.²⁰⁸ For example, in one study, subjects were given a variety of tests to determine if they had epilepsy or pseudoseizures. Among those tests, they received a saline injection (a pure placebo) after hearing the following deceptive instructions:

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

203. *Id.*

204. See Jeremy D. Slater et al., *Induction of Pseudoseizures with Intravenous Saline Placebo*, 36 *EPILEPSIA* 580, 580 (1995).

205. *Id.*

206. *Id.* at 584.

207. *Id.*

208. *Id.* at 580 (citing the literature).

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.²⁰⁹

Using this approach, almost all of those diagnosed with pseudoseizures were induced to have a seizure, while the technique did “not provoke seizures in patients with epilepsy.”²¹⁰ The researchers claimed that this technique was superior to basing diagnosis “solely on clinical appearance,” which “creates a serious risk of misdiagnosis.”²¹¹ Nevertheless, the AMA’s categorical prohibition on deceptive placebo use would prohibit the use of this test in clinical contexts.

2. *High Therapeutic Value*

In other cases, we may want to use placebos not for their diagnostic value but for their therapeutic value. 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 depression²¹² and knows of several researchers who claim that pharmaceutical antidepressants may not be much more effective than placebos.²¹³ The psychiatrist, therefore, provides the patient with two weeks worth of placebo pills and misleadingly states that they are antidepressants that are likely to help the patient without causing any worrisome side effects. After two weeks, the patient reports feeling much better. When the doctor reveals the nature of the pills, the patient is disconcerted at first, but the psychiatrist explains to the patient that the experience reveals the patient’s own ability to work through his emotional problems and shows that he will now be better able to manage depression with psychotherapy alone.

209. *Id.* at 582.

210. *Id.* at 584. One patient in the study was deemed to have both epilepsy and pseudoseizures. *Id.* at 585.

211. *Id.* at 584.

212. Brown, *supra* note 23, at 265; see Kirsch, *supra* note 28, at 167 (“23 percent of the response to antidepressant medication is due to spontaneous remission, 27 percent is due to the drug, and 50 percent is due to expectancy.”).

213. See Joanna Moncrieff & Irving Kirsch, *Efficacy of Antidepressants in Adults*, 331 *BMJ* 155, 157 (2005) (citing sources).

Of course, how one reacts to this story may depend in large measure on how it ends. That the story ends well is plausible, which is good reason to engage in further research before prohibiting the deceptive use of placebos. To 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 deceptive placebo,²¹⁴ (2) to document the use of a deceptive placebo, perhaps in hospital or patient medical records,²¹⁵ (3) to obtain the informed consent of a relative or guardian if possible,²¹⁶ and (4) to reveal to a patient that he was secretly given placebos within a reasonable time after commencing treatment.²¹⁷ I do not endorse any of these requirements in particular, but they illustrate the wide range of options available to limit deceptive placebo use without recourse to a categorical prohibition.

D. Unintended Consequences

The AMA prohibition is also likely to have unintended consequences. Its broad wording, taken literally, dictates informed consent practices in areas that were almost certainly never intended to fall under its purview. For example, the most common use of pure placebos, by a large margin, is in birth control treatment regimens, used by millions of women each day in the United States.²¹⁸ The majority of oral contraceptive treatments are sold in one-pill-per-day packets of twenty-eight pills, seven of which are placebos.²¹⁹ Unlike placebos designed to reduce pain or relieve anxiety, these placebos are designed to help women maintain a consistent pill-taking regimen, as irregular usage is a common reason why oral contraceptives fail to prevent pregnancy. According to one study, 47% of those taking birth control pills miss one pill per cycle and 22% miss two or more.²²⁰ Furthermore, “[w]omen who did not have an established routine for their pill-

214. Bok, *supra* note 27, at 59.

215. *Id.*

216. This precaution is likely inconsistent with current laws protecting patient privacy and might also sow intra-familial conflict.

217. On the other hand, this might be ill advised for reasons I discuss *infra*, Section III.F.

218. Michael J. Rosenberg et al., *Compliance, Counseling and Satisfaction with Oral Contraceptives: A Prospective Evaluation*, 30 *FAM. PLAN. PERSP.* 89, 89 (1998).

219. Martha Williams-Deane & Linda S. Potter, *Current Oral Contraceptive Use Instructions: An Analysis of Patient Package Inserts*, 24 *FAM. PLAN. PERSP.* 111, 111 (1992) (stating that 70% of women on oral contraceptives use a 28-day pill regimen with seven placebos, while 30% use a 21-day regimen with no placebos).

220. Rosenberg et al., *supra* note 218, at 90.

taking were 3.6 times as likely to miss two or more pills per cycle as were women who did have a routine.”²²¹

There are powerful reasons why doctors *should be required* to inform women of the placebo nature of their birth control reminder pills. It is important for pill-takers to understand that active pills and placebos are different, particularly because, if a woman misses a placebo, she need not respond as she would if she had missed an active pill (though these directions could be delivered without revealing that the placebos have no pharmacological effect).²²² Furthermore, many women want to know the placebo nature of their reminder pills because they would rather not engage in an otherwise meaningless pill-taking ritual seven times a month.

Nevertheless, given the connection between regularity of pill-taking and successful contraception, the precise method by which oral contraception instructions are given can, in the aggregate, lead to many unplanned pregnancies. Ought the director of a clinic that provides birth control pills to girls in their early teens be required to make perfectly clear that some pills are just reminders? Maybe yes, maybe no. The point is that the AMA prohibition, probably unintentionally, seems to take a stand on this issue. Furthermore, it takes a stand that is likely more aggressive about disclosure than the law of informed consent would have required prior to the AMA's placebo prohibition, as the failure to reveal that inert birth control pills are placebos probably would have been deemed too immaterial to create legal liability.²²³

E. Underinclusive and Easily Subverted

Another problem with the AMA policy is that it is underinclusive, permitting a great deal of behavior that differs only immaterially from prohibited conduct. The AMA expressly prohibits only the deceptive use of a “substance provided to a patient that the physician believes has *no* specific

221. *Id.*

222. Some birth control patient package inserts seem to gloss over the fact that some of the pills in the package have no medical purpose other than to serve as reminders. *See, e.g.*, Warner Chilcott, Ovcon Package Insert (March 2006), http://www.warnerchilcott.com/pdfs/pi/pi_ovcon_35-50_compact.pdf.

223. Perhaps one could argue that a birth control “treatment” consists not of individual pills but rather of a monthly set of pills. In that case, the monthly treatment taken as a whole *does* have specific pharmacological effects on fertility, such that the overall treatment is not a placebo. However, a treatment regimen that sometimes uses active drugs and sometimes uses pure placebos does require disclosure, according to the AMA's approach. *See* AMA REPORT, *supra* note 3, at 2. It is not clear why the happenstance of birth control packaging should lead to a different result.

pharmacological effect upon the condition being treated.”²²⁴ Thus, a doctor does not violate at least the “letter of the law” when he prescribes a substance that he believes has only a one in one-thousand chance (or even a one in ten-thousand chance) of having a specific pharmacological effect. As the probability of having a specific pharmacological effect gets low enough, however, the effect loses its medical significance. Thus, the AMA policy, narrowly construed, permits deceptive administration of what is essentially a placebo so long as there is a tiny, medically irrelevant possibility that the substance will have a specific effect.

Similarly, the AMA’s categorical prohibition can be easily subverted by adding minute quantities of active medications to inactive substances. Suppose a doctor creates a solution of morphine that is much more dilute than usual. The solution may well have a very high probability of having a specific pharmacological effect. However, as the morphine concentration gets sufficiently low, the morphine’s effect becomes clinically insignificant. Assuming that such treatments are permitted under the AMA policy, the policy is underinclusive relative to the AMA’s expressed goals. It hardly respects patient autonomy to prohibit deceptive treatments that have a zero probability of having specific effects while allowing deceptive treatments that have a high likelihood of having negligible specific effects.

Perhaps opponents of the AMA ban should be pleased that the ban is both underinclusive and easily subverted. On the other hand, some efforts to subvert the rule may have undesirable consequences. Without the new AMA policy, a certain number of doctors would have prescribed pure placebos. With the new AMA policy, however, use of pure placebos becomes riskier, because their use is hard to conceal. If a doctor’s deception unravels, he can offer no pretense to a professional discipline committee for giving a patient sugar pills. Thus, as a result of the new AMA policy, some doctors who would have prescribed pure placebos may instead prescribe impure placebos to make their deception harder to identify.

Such a shift may work against patient interests for several reasons. First, impure placebos are more likely to have harmful side effects than pure ones. Recall our earlier discussion of European doctors who prescribe magnesium as an impure placebo to ease patient anxiety.²²⁵ The magnesium supplements they prescribe, while generally quite safe, have riskier side effects and drug interactions than ordinary sugar pills have.²²⁶ Second, active medica-

224. AMA RECOMMENDATIONS, *supra* note 3, at 1 (emphasis added).

225. *See supra* Section I.B. Here, I make the assumption that these doctors believe that there is a zero probability that the magnesium will actually treat a mineral deficiency that causes anxiety-like symptoms, so that their use of magnesium clearly falls under the AMA prohibition.

226. *See* Univ. of Md. Med. Ctr., Magnesium, <http://www.umm.edu/altmed/ConsSupplements/Magnesiumcs.html> (last visited Dec. 6, 2007) (“Too much

tions are typically more expensive than inactive medications. Third, some active medications, like antibiotics, can be used in a manner that reduces the efficacy of the drug for everyone.²²⁷

If there is any advantage to prescribing magnesium over a sugar pill to treat depression, it comes from the fact that using magnesium makes the clinician's deception harder to detect. Yet the practice is no less deceptive. In fact, a clinician who prescribes impure placebos may be acting more deceptively precisely because the deception is more difficult to detect. Perhaps the higher financial costs and greater risk of side effects associated with impure placebos can be justified on the grounds that, by hiding patient deception, we create a façade of doctor-patient trust. Such a rationale, however, is entirely inconsistent with the AMA's stated interests in patient autonomy and joint doctor-patient decision making that prompted the creation of the prohibition in the first place.

F. Deception as a Scarce Medical Resource

Clearly there are many ways to misuse placebos. They may be used inappropriately to undermedicate pain, to dispatch with troublesome or annoying patients, or to soothe a patient temporarily at the expense of a more careful and accurate diagnosis. We need not rely on the AMA's placebo prohibition in such cases, however, as patients may be able to seek malpractice remedies for placebo misuse just as they would for any other negligent treatment. Even when used conscientiously, however, placebos do present risks that (1) patients will lose trust in their doctors if the deception is uncovered, particularly in an age where patients have increasingly sophisticated access to medical information and medical records; (2) patients will think they must have a pill or other medical treatments whenever they are sick, even when such treatments are not necessary; (3) patients will receive inadequate or improper care from other health professionals not involved in the deception who receive an inaccurate picture of the patients' medications; and (4) patients will develop placebo side effects, which can even include addictions to inert substances that the patients believe are active.²²⁸

magnesium can cause serious health problems including nausea, vomiting, severely lowered blood pressure, slowed heart rate, deficiencies of other minerals, confusion, coma, and even death. More common side effects from magnesium include upset stomach and diarrhea." Also, magnesium supplements can affect the activity of other pharmaceuticals. *Id.*

227. See Linder, *supra* note 17, at 2321 (citing evidence of antibiotic overprescription and recognizing the risk of bacterial resistance).

228. Sissela Bok recounts the following story:

In one case a psychotic patient was given placebo pills and told they were a "new major tranquilizer without any side effects." After four years she was taking 12 tablets a day and complaining of insomnia

A big concern about therapeutic deception is that patients who discover the deception will be upset and lose trust in their doctors or avoid seeking future medical care. Unfortunately, this claim has hardly been studied or carefully examined. Still, there are a few reasons to cabin the scope of this concern. First, I know of no evidence that deceptive pure placebos caused a loss in trust between doctors and patients in the days when deceptive pure placebos were used more frequently. Second, in particular cases in which a deceptive placebo is administered but never revealed, the patient remains unaware of the placebo use and develops no grounds to distrust his doctor. Third, in cases in which placebo administration is revealed but it has accomplished its intended purpose better than the available alternatives, it is not at all clear that patients will lose trust in their caregivers on account of the deception. If there are lingering feelings of distrust, patients may be eased by detailed explanations of the reasons that their doctors proceeded as they did. Nevertheless, even if we question whether patients *should* be upset about deception or whether they *should* distrust doctors who deceive them in a way that best promotes their health, as an empirical matter, therapeutic deception certainly may pose a risk to the doctor-patient relationship.

Importantly, concerns about the loss of patient trust go well beyond a fear that a particular patient will lose trust in his placebo-prescribing physician. After all, when deceptive placebos are skillfully employed, only a small minority of patients are likely to discover that they have been deceived.

I think a more serious threat is posed by the self-defeating quality of placebo deception. The more frequently that placebos are deceptively administered in society, the more patients will eventually become aware of the practice and begin to doubt that they have been administered “specific” therapies for their ailments, even when they have been. The mere possibility that one may deceptively receive a placebo is enough to weaken the placebo effect of all therapies. In order to retain a sizeable quantity of placebo-related improvement in all patients, we must not squander our use of placebos, for each use threatens the next.²²⁹

and anxiety. After the self-medication reached 25 pills a day and a crisis had occurred, the physician intervened, talked over the addictive problem (but not the deception) with the patient and succeeded in reducing the dose to two a day, a level that was still being maintained a year later.

Bok, *supra* note 18, at 20; see also BRODY, *supra* note 9, at 108 (noting that placebos can be addictive); Bok, *supra* note 27, at 58 (discussing placebo side effects, including addiction).

229. Even if patients are unaware that they are receiving placebos, the placebo effect may gradually diminish when repeatedly elicited. See Connie Peck & Grahame Coleman, *Implications of Placebo Theory for Clinical Research and*

Put differently, deceptive placebo use is a scarce medical resource. The more often therapeutic deception is used, the less effective it will be. Therapeutic deception cannibalizes itself. If there were no legal, moral, or stigmatic prohibitions on deceptive placebo use, doctors might overprescribe deceptive placebos. Doing so would make it harder for all doctors to treat their patients, as patients would begin to doubt the efficacy of whatever treatments they received—placebo or otherwise. Given this incentive structure, there may indeed be reasons to limit placebo use.

One piece of evidence that placebo efficacy could decline based on societal expectations of increased placebo use is supported by evidence of the opposite phenomenon: placebo effects increase when patients have heightened expectations of treatment efficacy. A 2002 article in the *Journal of the American Medical Association* examined clinical trials for depression published between 1981 and 2000. The studies showed significant variation in terms of the percentage of patients who showed clinically significant improvement from placebos, ranging from a low of 12.5% to a high of more than 50%.²³⁰ Importantly, the proportion of subjects responding to placebos increased over time, “at the rate of approximately 7% per decade, and a similar increase has occurred in the fraction of patients responding to active medication.”²³¹ The researchers think that there has been a genuine change in the rate of placebo response that “does not appear to be directly explained by changes in study characteristics.”²³² One possibility is that placebo response rates are changing because subjects with milder, easier-to-treat depression are increasingly participating in research experiments.²³³ This explanation is still speculative, however, leading one researcher to joke, “They’re making placebos better and better.”²³⁴

Placebo responses to antidepressants may indeed be getting better and better, particularly if the public has raised its expectations of the likelihood that such drugs will help them, perhaps from increased direct-to-consumer pharmaceutical advertising. Of course, if perceptions of drug efficacy can change for the better, they may also change for the worse. Such might be the

Practice in Pain Management, 12 THEORETICAL MED. 247, 252 (1991) (discussing “placebo sag”); accord Boozang, *supra* note 8, at 719.

230. B. Timothy Walsh et al., *Placebo Response in Studies of Major Depression: Variable, Substantial, and Growing*, 287 JAMA 1840, 1842 (2002).

231. *Id.* at 1844.

232. *Id.*

233. *See id.*

234. Jay Dixit, *New! Improved! And Still 100 Percent Fake*, WASH. POST, May 18, 2002, at B1 (quoting Walsh).

case if the public gradually increased its suspicions that doctors are deceptively prescribing placebos.

As noted, there are other reasons to limit deceptive placebo use. Doctors might be inclined to overuse placebos to save themselves time or money at the expense of a more careful diagnosis or of a more satisfying long-term doctor-patient relationship. Yet, none of these concerns demonstrates that the optimal level of therapeutic deception is zero. Even if malpractice remedies underdeter inappropriate placebo use because placebo deception is hard to detect, a categorical ban may still be excessive.

The current level of therapeutic deception, as surveys show, is well above zero; yet relatively few patients seem to fear that their doctors are prescribing placebos. It is, admittedly, an open question whether the current level of therapeutic deception in the United States, poorly understood as it is, is too high or *too low*. Given all the uncertainty, why do I say that a prohibition is not yet justified? Why do I put the burden on the ban's supporters to justify the prohibition rather than give myself the burden of justifying its absence? The answer, I will suggest in the next Part, relates to the paucity of litigation on placebo deception.

IV. BURDEN-SHIFTING AND PROPOSED RESEARCH AGENDA

In this Part, I suggest that while there are many possible reasons why deceptive placebo use is so rarely litigated, the fact that there are so few complainants ought to have given the AMA pause before enacting a categorical prohibition. I also propose an interdisciplinary research agenda to enable us to better understand the reasons why placebo deception is so rarely litigated and to better regulate deceptive placebo therapies. I conclude by noting how the issues raised by deceptive placebos recur in other areas of law and public policy as part of the debate over beneficent deception more generally.

A. Explaining the Paucity of Cases

While informed consent negligence and battery claims are probably the most obvious sources of liability for those who deceptively administer placebos, there are other theories that plaintiff-patients could pursue. In some cases, doctors who deceptively use placebos may face liability under theories of fraud, breach of contract, breach of fiduciary duties, and non-informed-consent theories of malpractice. Doctors also risk sanctions by professional disciplinary committees.²³⁵ They could even face criminal charges for battery or for selling a simulated controlled substance.²³⁶ Despite plausible

235. See *supra* note 6.

236. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 482.002 (Vernon 2003) (making it a crime to “knowingly or intentionally . . . deliver[] a simulated controlled substance” while expressly or implicitly representing that it is a con-

theories for taking action against physicians and other health professionals for deceptive placebo use, however, it almost never happens.

While a number of published cases have fact patterns that describe or allege deceptive placebo administration,²³⁷ only one case addresses the practice directly (under a theory of fraud, perhaps because the statute of limitations had run on malpractice-related claims). In the 1976 case of *Jurcich v. General Motors Corp.*,²³⁸ plaintiff Emil Jurcich was a factory worker who injured his back on the job and was treated for the injury by a nurse and doctor at the plant dispensary.²³⁹ Among his treatments, he was secretly given sugar pills.²⁴⁰ Jurcich eventually discovered the deception at a worker's

trolled substance). Importantly, this statute makes an exception for medical practitioners "acting in the legitimate performance of [their] professional duties," *id.*, though the practice of placebo deception seems less legitimate after the AMA prohibition. *See also* *State v. Marion*, 27 P.3d 924, 926-27 (Kan. Ct. App. 2001) (overturning a conviction for possession with intent to deliver a simulated controlled substance because the defendant's imitation crack cocaine did not have labels or promotional materials indicating that the substance simulated a controlled substance as required for conviction under the Kansas statute); *Boykin v. State*, 818 S.W.2d 782 (Tex. Crim. App. 1991) (*en banc*) (interpreting the Texas statute).

237. *See, e.g.*, *Burton v. Cameron County*, 884 F. Supp. 234, 239 (S.D. Tex. 1995) (prisoner's assault and battery claims against medical personnel for use of placebo barred by statute of limitations); *Lawhorn v. Duckworth*, 736 F. Supp. 1501, 1502 (N.D. Ind. 1987) (prisoner alleges placebo administration in lieu of necessary medications); *Ching v. Hotz*, 204 So.2d 73, 73-74 (La. Ct. App. 1968) (undisclosed form of placebo probably used to calm the patient's nerves); *State ex rel. Gibson v. Missouri Bd. of Chiropractic Exam'rs*, 365 S.W.2d 773, 777 (Mo. Ct. App. 1963) (chiropractor appealing license revocation for unlicensed practice of medicine claims use of inert placebo was for a "psychological effect[]" to encourage patient to take vitamin pills and that use of ear drops containing benzocaine at "about 1/25 of the quantity required for medical effect . . . does not make the ear drops 'medicine'"); *Harder v. F.C. Clinton, Inc.*, 948 P.2d 298, 307 (Okla. 1997) (sterile water injections for pain complaints).

238. 539 S.W.2d 595 (Mo. Ct. App. 1976).

239. *Id.* at 597. As an aside, the name of the physician was Dr. Patient. When a person has a name that is well suited to his interests or profession (for example, the poet William Wordsworth or the neurologist Lord Brain), the name is called an aptonym. *See* Sam Roberts, *Ms. Rose, by Any Other Name, Might Still Be a Florist*, N.Y. TIMES, Mar. 27, 2005, at 12. In this case, the doctor's name was distinctly incongruent with his profession and should perhaps be known as an "inapronym."

240. *Jurcich*, 539 S.W.2d at 597.

compensation hearing²⁴¹ and later brought suit against his doctor, his nurse, and General Motors for fraud.²⁴² The Missouri Court of Appeals found that placebos are “a recognized form of medical treatment,” and quoted Jurcich’s expert, who said that you never tell a patient you are giving him a placebo because “[y]ou are hoping that you will fool him.”²⁴³ The court affirmed the lower court’s directed verdict against the plaintiff, expressing doubts that Jurcich presented a fraud claim. The court concluded that he more properly raised a question of malpractice.²⁴⁴

The *Jurcich* court seemed to find that, even if the therapy involved deception, so long as it was a legitimate medical practice, it was not fraudulent. Importantly, however, the court relied on the fact that Jurcich could not show any pecuniary loss from the alleged fraudulent conduct.²⁴⁵ The unusual circumstances that led Jurcich to receive free medical treatment and hence suffer no pecuniary loss, therefore, leave some open questions. Indeed, a major logistical difficulty in deceptive placebo treatment is to figure out how to charge a patient for what are usually less expensive treatments without thereby revealing the deception.²⁴⁶ In any event, *Jurcich* is too idiosyncratic and outdated to enable a meaningful prediction about whether therapeutic deception can constitute fraud, given the gradual increase in informed consent disclosure requirements over the last several decades and, of course, the AMA’s recent change to its Code of Medical Ethics.

The fact that there is only one reported case litigating the issue of deceptive placebo use raises the following question: If there are plausible theories for taking legal action against physicians for deceptive placebo use, and there is substantial evidence that deceptive placebos are used frequently, why are there not more cases?²⁴⁷ In the context of deceptive impure placebos, the answer is not so surprising. As noted, it is extremely difficult to determine when a physician is prescribing an impure placebo, since it is often easy to present a plausible theory in which the prescribed medication could have a positive specific effect on the patient. Therefore, many of these cases are litigated as simple malpractice cases where a physician is accused of

241. *Id.* at 599.

242. *Id.* at 595-97. Dr. Patient died prior to trial, *id.* at 598 n.1, and does not appear in the case caption.

243. *Id.* at 600.

244. *Id.* at 599-600.

245. *Id.* at 600-02.

246. Boozang, *supra* note 8, at 741.

247. There are certainly plenty of cases alleging other kinds of violations of informed consent. A Westlaw search for “informed consent” turns up thousands of cases.

failing to adequately diagnose or treat some condition, and the issue of patient deception gets lost. Determining that a physician's treatment was placebo-motivated would be difficult indeed and perhaps unnecessary where the doctor otherwise committed malpractice.

As for the virtual absence of cases evaluating pure placebo use in the therapeutic context, we could imagine two very different sets of explanations. Proponents of deceptive placebo use might note: (1) placebos are often helpful to patients; (2) some patients are open to receiving deceptive placebos; and (3) patients rarely discover the deception, and when they do discover it, the harms are so trivial that they are not inclined to take legal action. Opponents of deceptive placebo use might suggest: (1) many patients have their autonomy interests violated by deceptive placebo use but are just unaware of it and cannot bring suit; (2) when they happen to discover deceptive placebo use, they are very upset but are unable to bring action because they cannot demonstrate sufficient harm to make it worth a lawyer's attention; (3) lawyers have been deterred from bringing suits because of the absence of supporting precedent; and (4) in contradistinction to the preceding two points, when patients do have a cause of action, we do not see published cases because doctors recognize the egregiousness of their actions and settle quickly.

B. Proposed Research Agenda

The complete story of why there has been so little litigation over deceptive placebo administration probably falls in between a purely pro-placebo and a purely anti-placebo explanation. Nevertheless, I think the dearth of cases addressing these legal issues should have given the AMA pause before adopting its categorical prohibition. If deceptive placebos are harmful enough that they should be prohibited, where are the complainants? We know that it is difficult to deceive patients when pure placebos are used. Surely, some patients must discover the deception. Even if deceptive pure placebo use has been on a sharp decline, why do we not have more cases from preceding decades while the transition was occurring?

The AMA prohibition increases physicians' legal liability and their risk of professional discipline. It also gives doctors incentives to shift from pure placebo administration to the arguably more harmful practice of prescribing impure placebos—all this to prohibit a practice for which we have little evidence of harm in the form of complaining parties and much evidence to suggest that it can be therapeutic. At a minimum, the AMA could have simply deferred any determination about deceptive placebo use until more evidence is gathered.²⁴⁸

248. Prior to the adoption of its placebo prohibition, the AMA appeared agnostic about the use of deceptive placebos. The AMA has long required doctors to "be honest in all professional interactions" and to "strive to report physi-

I, therefore, propose an interdisciplinary research effort to help us draft better policies with respect to deceptive placebos. Perhaps most importantly, we need to understand more about the therapeutic value of placebos. In particular, we need to know more about: (1) the symptoms that show improvement with placebos; (2) the extent and duration of placebo-generated improvement and how these factors vary, if at all, by patient characteristics;²⁴⁹ (3) the diagnostic value, if any, of using deceptive placebos; (4) the extent, if any, to which *revealed* inert substances create placebo effects without requiring deception; (5) the relationship between partial deception (through advance consent forms or partially deceptive instructions) and placebo effectiveness; (6) the effects on a patient's well-being of revealing the placebo nature of a previously effective, concealed placebo; and (7) the relative costs and benefits of using placebos as compared to other ways of eliciting placebo-like effects by, for example, fostering more reassuring doctor-patient relationships.

There is an even bigger void in our understanding of the sociology of deceptive placebo administration, especially in the United States. In particular, we need to know more about: (1) the extent to which doctors and other health professionals report using and, as best we can determine, actually use pure or impure placebos; (2) their beliefs about placebo efficacy and diagnostic value and how these beliefs are affected by features of their medical training; (3) the reasons for their decisions to use or refrain from using a placebo; and (4) the extent to which their views have already been shaped by perceived legal, moral, or stigmatic pressures to avoid using placebos and how they might behave in the absence of those pressures.

Patients and potential patients could be asked similar questions, including questions about: (1) their preferences (and the rigidity of their prefer-

cians . . . engaging in fraud or deception." AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS princ. II (2001), available at <http://www.ama-assn.org/ama/pub/category/2512.html>. In addition, AMA policy has long required doctors to obtain the informed consent of patients. AM. MED. ASS'N, H-140.989 Informed Consent and Decision-Making in Health Care, http://www.ama-assn.org/apps/pf_new/pf_online (use Policy Finder). Nevertheless, these broad statements are not generally thought to speak directly to the issue of deceptive placebos. According to Sissela Bok, there is no evidence that the AMA's principle requiring honest dealings has been thought to apply to deceptive placebo administration. Bok, *supra* note 27, at 55; see also Randy Cohen, *Testing, Testing*, N.Y. TIMES, Jan. 29, 2006, § 6 (Magazine), at 18 (stating, prior to the recent changes, that the AMA's code of conduct is silent as to whether doctors may deceptively administer placebos).

249. It has been surprisingly difficult to identify which characteristics of patients, if any, make them more likely to respond to placebos. Anne Harrington, *Introduction to THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION*, *supra* note 9, at 1, 2-3.

ences) with respect to the use of deceptive placebos on themselves and on their close relatives, (2) their beliefs about the frequency with which placebos are actually used, (3) their expected loss of trust in a practitioner who used deceptive placebos, and (4) their preferences as to whether they would want placebo deception revealed if they responded well to a deceptive placebo treatment.

Relatedly, some empirical legal research might uncover better explanations for the paucity of deceptive placebo cases. For example, it would be helpful to gather data on litigation settlements and professional disciplinary actions in the area of deceptive placebos. Perhaps hospital administrators could comment on their familiarity with lawsuits related to placebo deception. Perhaps survey data or anecdotal research could uncover whether those who subsequently discovered receiving deceptive placebos considered bringing or, in fact, brought legal action against their health professionals.

No doubt, there are many factors to consider when evaluating the relative merits of deceptive placebo treatments. Some inquiries raise their own ethical questions, particularly when studies of the placebo effect work best on deceived patients.²⁵⁰ Yet, the research is much needed both because placebos, in one form or another, are frequently used and because placebo effects may explain some of the therapeutic value of virtually every treatment. Furthermore, the efficacy of almost the entirety of our medical apparatus is based on comparisons between experimental treatments and placebo treatments. All of this research is on surprisingly shaky ground when placebos, the constant companion of our research experiments, are so poorly understood.

CONCLUSION

Therapeutic deception is an example of the more general phenomenon of beneficent deception, meaning any instance in which a person deceives another when the deception is motivated (at least in part) by a desire to benefit the deceived. Some instances of beneficent deception may occur in mundane social interactions. For example, in a book on writing advice, Robert Boice describes a technique he has used to help others overcome writer's block. Boice states that he would have "a blocked writer describe what he or she would write about if the block were magically removed,"²⁵¹ while he surreptitiously recorded the response. At their next meeting, he

250. See Miller et al., *supra* note 99. Compare Lisa Bortolotti & Matteo Mameli, *Deception in Psychology: Moral Costs and Benefits of Unsought Self-Knowledge*, 13 ACCOUNTABILITY IN RES. 259 (2006) (defending some uses of deception in psychological research) with Andreas Ortmann & Ralph Hertwig, *The Costs of Deception: Evidence from Psychology*, 5 EXPERIMENTAL ECON. 111 (2002) (supporting a prohibition among experimental economists on deceptive research).

251. ROBERT BOICE, *PROFESSORS AS WRITERS* 2 (1990).

would present a typed transcript made from the recording—a technique which “worked beautifully to get writers started,” though “it annoyed many of them.”²⁵² Thus, Boice misled those who sought his advice in an effort to advance their writing, the very reason they sought his aid in the first place.

Others instances of beneficent deception speak directly to core features of government transparency. For example, in the late 1990s, administrators in the White House Office of National Drug Control Policy made a deal with television networks that, in essence, used funds devoted to public service announcements to instead weave anti-drug messages into popular television shows like *ER*, *Beverly Hills 90210*, and *The Cosby Show*.²⁵³ By doing so, the government quite likely expected to convey its beneficent anti-drug message more effectively, more expansively, and less expensively than it would have otherwise.²⁵⁴ The typical viewer, however, could easily be misled into thinking that he was watching a show devoid of government-sponsored advertising;²⁵⁵ indeed, that very misconception may have made the anti-drug message more effective.²⁵⁶

252. *Id.*

253. Bonnie Brennen, *Communication and Freedom: An Althusserian Reading of Media-Government Relations*, 7 JAVNOST—THE PUBLIC 5, 10-11 (2000). For example, Barry McCaffrey, then-director of the White House Office of National Drug Control Policy, told a House appropriations subcommittee: “An on-strategy story line that is the main plot of a half-hour show can be valued at three 30-second ads. If there is an end tag with an 800 number for more information at the end of a half-hour show, it is valued at an additional 15-second ad.” *Id.* at 14 n.2.

254. The anti-drug program as a whole, however, has been criticized for its ineffectiveness. See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-06-818, ONDCP MEDIA CAMPAIGN: CONTRACTOR’S NATIONAL EVALUATION DID NOT FIND THAT THE YOUTH ANTI-DRUG MEDIA CAMPAIGN WAS EFFECTIVE IN REDUCING YOUTH DRUG USE (2006), available at <http://www.gao.gov/new.items/do6818.pdf>.

255. Not surprisingly, a GAO report on the subject conveys a different gloss, stating that one of the jobs of the program was to “work with the entertainment and media industries to encourage the accurate depiction of the consequences of drug use.” *Id.* at 9.

256. More broadly, John Rawls and others have argued that bedrock principles of ethical conduct should be capable of public dissemination without thereby contradicting the principles themselves. See JOHN RAWLS, A THEORY OF JUSTICE 133 (1971) (advocating a “publicity condition” on moral principles); see also Bernard Williams, *A Critique of Utilitarianism*, in J.J.C. SMART & BERNARD WILLIAMS, UTILITARIANISM: FOR AND AGAINST 77, 138-39 (1973) (suggesting that governments operating under secret utilitarian principles are apt to be manipulative and coercive); Larry Alexander, *Pursuing the Good—Indirectly*, 95 ETHICS 315, 326 (1985) (stating that, according to Rawls, “moral

When we evaluate the merits of beneficent deception, we are presented with difficult tradeoffs between the value of honesty and candor compared to whatever substantive benefits the deceiver attempts to convey through deception. Importantly, in the medical context, patients go to doctors in order to feel better, not to develop an honest and candid relationship. Of course, honesty and candor often facilitate effective treatment. They are not, however, primary goals of the healthcare system.

If a prohibition on deceptive placebos can be justified, the justification will have to appeal to more than just concerns about deception *simpliciter*, because placebo deception is a very particular kind of deception. A plausible justification for prohibiting placebo deception will likely refer to the set of potentially harmful consequences from deceptive placebo use—including, as I suggest, a reduction in the placebo effect from all treatments that arises when patients suspect that they are receiving placebos. I am skeptical that it is always unethical to administer deceptive placebos to a patient, but agnostic as to whether a general prohibition might be justified by empirical evidence of system-wide harms caused by placebo deception. Importantly, however, any prohibition intended to prevent the harmful consequences from the practice of deceptive placebo administration should be able to identify and characterize those consequences—something that we are currently unable to do with any precision. The lack of complaining parties, though an ambiguous signal, is some evidence that a categorical prohibition is unwarranted, especially as research accumulates to show that placebos have genuine therapeutic value and offer a treatment option that is unparalleled in its ability to reduce pain at little financial cost and with little risk of side effects. Additional research can no doubt show how we can limit the use of placebo deception, just as we limit the use of other scarce medical resources, without entirely prohibiting the practice.

Therapeutic deception, indeed beneficent deception more generally, raises challenging questions about how we ought to trade off such incommensurables as honesty and pain relief, truth and comfort. When a person is deceived for his own benefit, there is a fear that the deceiver, however well intentioned, will value these tradeoffs differently than would the deceived he intends to benefit. Whether this fear is well founded likely depends on the particular setting in which the beneficent deception occurs. In the healthcare context, categorical prohibitions on beneficent deception, in an effort to claim the moral high ground, fail to adequately recognize that beneficent deception can, in fact, be beneficent. Indeed, if the categorical prohibition on placebo use increases patient suffering by reducing treatment options, its claim to the moral high ground appears increasingly deceptive.

principles are invalid if they cannot be publicly advocated without being self-defeating”).