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How Placebo Deception Can Infringe Autonomy

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dangerously misleads patients, is not substantiated as effective, and cannot be ethically supported as a treatment. ■

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In "A Limited Defense of Clinical Placebo Deception" (Kolber 2007), I argued that, given our current understanding of placebo efficacy and patient preferences, we should not categorically prohibit physicians from using placebos deceptively. While Foddy (2009) supports my conclusion, he goes much further in his defense of placebo deception in ways that are unwarranted. I will limit my brief comments to Foddy's discussion of autonomy. In particular, I will show why Foddy fails to establish his claim that the responsible use of placebo deception "is *never* a threat to patient autonomy" (4) and "does not diminish the patient's autonomy at all" (4).

Foddy (2009) never tells us precisely what he takes autonomy to be. But he does address claims that placebo deception infringes patients' autonomy by reducing their ability to determine their medical futures. He argues, for example, that placebos "cannot prevent the patient from seeking worthwhile alternatives" (4) because, in cases of responsible placebo deception, there are no worthwhile alternatives.

As autonomy is usually understood, however, so long as people have certain basic mental capacities, we treat them as autonomous decision-makers even when they are acting irrationally. The unavailability of rationally-desirable alternatives does not change the fact that placebo deception can restrict patient autonomy. A law that prohibits you from counting grains of sand at the beach may limit your autonomy even if counting grains of sand serves no worthwhile purpose. Similarly, a medical ethics regime that, in effect, prohibits you from declining placebo treatments may limit your autonomy, even if you have no worthwhile alternatives.

Foddy (2009) says that physicians can "characterize placebos as a source of temporary, symptomatic relief" (2009) so that patients can still autonomously choose other treatments. But when patients do so, they will not be choosing with the sort of information that many of them would like to have. Sometimes the desire for the information could be quite rational. If a person ends up in the emergency room in an unfamiliar locale, he wants to give his treating physicians the most accurate information possible about his current medications. With false information, his doctors may decline to use a highly effective treatment out of fear that it could interact with the medication the patient mistakenly thinks he is taking. Concern about such possibilities hardly seems irrational.

More importantly, placebo deception can limit a patient's autonomous ability to decline treatment, even when the patient would have declined for entirely idiosyncratic reasons. Suppose, for example, that a patient has religious dietary restrictions that prohibit him from eating the inert gelatin in a placebo capsule, *unless* the capsule constitutes medication. Let us also assume that placebo treatments do not qualify as medications for purposes of overriding his religious restriction. In such a case, deceiving the patient about the placebo nature of the treatment *does* interfere with the patient's autonomous decision to respect his dietary restriction. It does so whether his religious practices are rational or irrational, worthwhile or pointless. Foddy (2009) seems to be defending paternalistic deception, not autonomous decision making.

Rather than claiming that placebo deception never threatens to reduce patient autonomy, I have argued that placebos may interfere with patient autonomy but do so less frequently than one might think (Kolber 2007, 106–108; 114–127). In fact, if we knew that a particular patient was generally willing to be deceived, refusing to deceive the patient might limit the patient's autonomy (Kolber 2007, 117–118). The mere fact that placebo deception sometimes infringes autonomy, however, is not enough to justify categorically

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prohibiting placebo deception. After all, lots of laws infringe autonomy. Autonomy is hardly the only relevant consideration. In fact, I argue, a better reason for limiting placebo deception is that it is a scarce medical resource. The more that doctors prescribe placebos deceptively, the more patients will have reason to be suspicious about the efficacy of all treatments they receive—whether placebos or not (Kolber 2007, 124–127).

Another problem with Foddy's (2009) article is that, even though it has the title, "A Duty to Deceive," he never actually defends such a duty. It is not clear from the article who, if anyone, is supposed to have a duty to deceive. He states that the American Medical Association (AMA [Chicago, IL]) should endorse placebo use, but endorsing placebo deception is not itself deception. So, he is not arguing that the AMA has a duty to deceive. Nor does an AMA endorsement of placebo deception necessarily give doctors a duty to deceive. It depends on the nature of the endorsement. Thus, it is not clear whether Foddy believes that, in certain circumstances, a physician has a *duty* to use placebos deceptively.

If Foddy believes that physicians have duties to use placebos deceptively, he has yet to defend the claim. After all, physicians have autonomy interests, too. The mere fact that some treatment may be in a patient's best interests does not automatically mean that the physician has a duty to provide the treatment. There is controversy over whether doctors must prescribe treatments to which they have moral or religious objections. Indeed, doctors might have moral objections to deceiving their patients using placebos. Again, even if they *should* have no such qualms, they may still have autonomy interests in conducting themselves according to their own moral and religious values.

While the concept of autonomy is extraordinarily ambiguous and often clouds meaningful debate, under any plausible conception of the term, placebo deception can infringe patient autonomy. And if doctors have duties to use placebos deceptively, then such duties may infringe their autonomy, too. I believe that, given our current understanding of placebo efficacy and patient preferences, there are good reasons not to categorically prohibit placebo deception. Unlike Foddy, however, I defend placebo deception under limited circumstances, *even though* such deception sometimes infringes legitimate autonomy interests. ■

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The Placebo Response: The Shared Construction of Reality and the Illusion of Autonomy

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Autonomy defined by Beauchamp and Childress (2001) as the "personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding" (57–59) has become one of the central organizing bioethical principle of (post) modern medicine.

Patients are typically described as 'healthcare consumers' who must navigate a modern marketplace flooded by a tidal wave of highly technological medical options. As a consumer, the modern 'patient' is viewed as an autonomous agent whose healthcare decisions are created through their particular idiosyncratic thought processes. Under the guise of 'therapeutic neutrality' and supporting 'patient-centered decision-making', clinicians are trained to avoid being paternalistic out of fear that they may violate their patients' right to autonomous decision-making. This "abandonment to autonomy" (Loewy 2005) often leaves our patients confused, anxious, and sometimes vulnerable to manipulation. This is particularly concerning in the context of profit driven industry-sponsored drug trials built on the foundation of placebo-controlled randomized clinical trials that include a placebo control. Despite the apparent ethical support for such clinical and research standards of practice, recent neuroscientific discoveries about the placebo response and the decision-making process challenge the ethical validity of 'autonomy' and suggest that patients would be better

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