

## When Subtle Deception Turns into an Outright Lie

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In "A Duty to Deceive: Placebos in Clinical Practice" Bennett Foddy argues that the deceptive use of placebos should be a regular part of medical practice. This would cast the clinical encounter as a kind of magic show. During the performance, the patient would know that not everything is what it appears to be--the patient may receive a deceptively kind word or a deceptive prescription. And yet, like the illusionist's audience, the patient would know that all will turn out well in the end. Foddy worries less about such a relationship--with deception built in--than others might because, as he argues, it would not undermine patients' autonomy, would not coerce patients, and would not damage the foundational trust of the physician-patient relationship. Support for this position is found in a number of dubious absences--the absence of research on the effectiveness of placebos, the absence of the possibility for clinical research on placebos, the absence of known effective therapies for some medical conditions, and the absence of a pharmacological harm caused by placebos. These absences, however, raise questions as much as they support Foddy's position. What functions as the "placebo" in a trial to test placebo effectiveness? Why claim that there is a "categorical ban on deception in scientific research" (6, 6-7) when research in psychology regularly involves deceiving subjects? Should non-traditional medicine's effectiveness be considered as well? That is, who is consulted to determine "known effective" treatments? And when should non-pharmacological harms be considered?

Provocative as they may be, the arguments in this essay are fraught with difficulties

and tend to be unpersuasive. For example, in the conclusion, Foddy conflates pharmacological harms with all harms: "What we can be completely certain of is that *placebos are not harmful*. A doctor never *harms* a patient in any *pharmacological sense* by prescribing placebo." (15, 15-18, emphasis added) Taken together these sentences conflate pharmacological harms with all other harms, rendering the argument problematic at best. Nonetheless, I will leave all of these issues, as well as issues of placebo effectiveness<sup>1</sup> and general deception in the clinical encounter, aside. I do this to focus on a more fundamental oversight in the argument--the conflation of deception and lying.

It is unclear if the paper includes a distinction between deception and lying. Take the example of deception in medical research: "the best known case of *deception* in medical research is the Tuskegee Syphilis Study." (10, 29-30, emphasis added) As Allan Brandt notes in his provocative analysis of the Tuskegee Syphilis Study, however: "Further difficulties [for the Tuskegee Syphilis Study] arose in enlisting the subjects to participate in the experiment . . . Vonderlehr found that *only the offer of treatment* elicited the cooperation of the men. They were told they were ill and were promised free care. Offered therapy, they became willing subjects." (24, emphasis added) This was not a deception—this was a lie.

Even though they serve similar purposes, lying and deception incorporate different strategies and so affect relationships in different ways. Most notably, lying occurs when an individual explicitly states something as true that he or she knows to be false. For example, if I were to say, "I live in Manhattan," that would be a lie (I live in Brooklyn). Deception occurs when true or ambiguous statements are used in such a way to create a

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<sup>1</sup> See Miller and Colloca (2009)

false belief in the listener. If I were in a conversation about where I live and I implied I live in Manhattan by saying, “I really hate getting out of the city” or “Manhattan is the only place to live,” that would be deception. Both deception and lying serve to create a false belief, but they differ as follows. With deception, a healthy dose of cynicism may keep an individual from being led to a false belief—by directly asking if I live in Manhattan, a false belief caused by deception can be avoided. With lying, only absolute distrust in the other will avoid a false belief—the only avenue to avoiding the false belief that I live in Manhattan when I lie is to distrust every utterance of mine.

The example of Tuskegee is not the only conflation of deception and lying. Take for example the discussion of the norms that govern medical practice: "Tempted though they may be, ethical guidelines do not permit doctors *to lie to a patient* for any reason. In medical practice, as in scientific research, it is deemed that there are no exceptions to *the rule against deception*." (11, 6-9, emphasis added) "Permission to lie" is permission to make false statements. A "rule against deception" is a rule against intending to create false beliefs.

Look also to the brief discussion of Kant: "Few people agree [with Kant] that our duty to speak truly is so demanding. In nearly every sphere of life, there are special circumstances in which we accept that *deceptive speech* is justified. The duty to *tell the truth* is merely a prima facie duty, not an absolute one." (10, 51-54, emphasis added) Again, one can speak deceptively and still tell the truth. Imagine the physician who is in the process of prescribing a placebo. The patient asks what the prescription is for and the physician replies, "I think it's the prescription that gives you the best chance for getting better." So long as the physician believes it to be true, he or she would be both telling the

truth, but also being deceptive--such statements would likely lead the patient to the belief that they are receiving an active medication.

On its own, the conflation of deception and lying may be only an academic mistake. For this paper, however, it creates a dilemma. Failing to acknowledge the distinction contributes to a failure to discuss whether physicians should actually *lie* to their patients in the process of prescribing placebos. This question is pivotal.<sup>2</sup> If physicians are to tell the truth, the practice of prescribing deceptive placebos would have a short half-life. Patients would more frequently ask about placebos to ensure that the medications they are taking are actually medications.

If physicians are to lie, then the account has a devastating problem. Foddy argues that the deceptive use of placebos does not necessarily, nor will it likely, undermine the trust between physician and patient. Even in the case where physicians only deceive patients, Foddy's conclusion is contentious. Patients may find some deception understandable, but they may very well become cynical of physicians as fiduciaries. A relationship of trust is not typically characterized by cynicism. Further, if physicians are in a position to lie to their patients, patients are likely to be more than cynical--they may very well distrust everything the physician has to say. Such distrust contradicts the fiduciary nature of the physician-patient relationship and would devastate the foundational trust that allows patients to make intimate revelations about themselves to their physicians.

Foddy offers the beginning of an answer to this worry: "I am not sure that patients have an expectation of complete honesty from their physicians. . . . But even if patients

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<sup>2</sup> For an interesting discussion of deception, lying, and the professions more generally, see Ellin (1982).

hold this expectation, they ought not to hold it with regard to the deceptive use of placebos.” (13, 51-52) Such a view of patient attitudes seems a bit optimistic. Will patients neatly circumscribe areas of trust (e.g., disclosing intimate details, accepting referrals to specialists) from areas of distrust (e.g., prescriptions)? Will this distrust about the possibility of placebos have no effect on patient willingness to fill and follow prescriptions that are not placebos? To develop this claim as a persuasive response to the worry, a great deal more needs to be said about the realistic expectation of compartmentalized distrust.

Whether or not the other arguments in the paper are persuasive, lacking an account of the distinction between lying and deception, the paper is foundationally unsettled. In this short commentary, I have focused on how this oversight could unsettle the trust that grounds the fiduciary relationship between physicians and patients. This oversight also unsettles the argument that placebo prescriptions are not coercive and do not undermine patient autonomy. At first blush, both of these are also at stake if physicians are encouraged to lie to their patients. And yet, I will leave these matters for a longer treatment of the subject.

## References

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