

Informed Consent, the Placebo Effect, and The Revenge of Thomas Percival

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“I'm addicted to placebos. I could quit, but it wouldn't matter.”¹

INTRODUCTION

In 1957 a California man now known only as “Mr. Wright” was diagnosed with advanced lymphosarcoma cancer. When all known treatments proved ineffective, he entered a clinic, and was given only days to live.² Wright then learned of the clinic’s pending study of Krebiozen, a horse serum suspected of being effective in treating cancer. The clinic rejected Wright’s request to participate in the study because he did not meet the minimum life expectancy requirement of three to six months.³

From his “deathbed,” Wright then “begged” his psychologist, Bruno Klopfer, to administer the substance to him.⁴ Dr. Klopfer complied and injected Wright with Krebiozen on a Friday afternoon. On Monday, Dr. Klopfer reported:

I had left him febrile, gasping for air, completely bedridden. Now, here he was, walking around the ward, chatting happily with the nurses and spreading his message of good cheer to any who would listen. Immediately I hastened to see the others [in similar condition who had not received Krebiozen]. No change, or change for the worse was noted. Only in Mr. Wright was there brilliant improvement. The tumors had melted like snowballs on a hot stove, and in only these few days, they were half their original size! This is far more rapid regression than most radio-sensitive tumors could display under heavy X-ray given every day.⁵

Two months later, Wright’s cancer was still apparently in remission when he read conflicting reports in the news regarding Krebiozen’s effectiveness.⁶ When the tumor masses

reappeared, Dr. Klopfer, interested in “how quacks achieve some of their well-documented cures,”⁷ injected Wright with water which, he claimed was “a new super-refined double strength” version of Krebiozen.⁸ The tumor masses again “melted” and Wright was “the picture of health” for two more months.⁹ When Wright read a conclusive American Medical Association (AMA) announcement that “[n]ationwide tests show Krebiozen to be a worthless drug in treatment of cancer,” he died two days later.¹⁰

Physician Bernie Siegel, a Yale University School of Medicine surgeon and past president of the American Holistic Medical Association,¹¹ recently recounted a similar occurrence. A physician informed a patient that “she was going to die soon” of cancer.¹² Without her physician’s knowledge, the woman went to Mexico to undergo treatment with laetrile, an apricot pit derivative¹³ unavailable in the United States and later proven ineffective in treating cancer.¹⁴ Three years later, the patient met her physician on the street and informed him of her laetrile treatments in Mexico.¹⁵ The physician responded, “That’s absolutely crazy nonsense.”¹⁶ The patient died within a week.¹⁷

Both anecdotes involved the use of placebos, or sham medical treatments.¹⁸ Integral to the outcome in each case was a physician’s deceit of, or failure to deceive his patient. Dr. Klopfer explicitly deceived his patient. Dr. Siegel criticized the physician in his story for failing to embrace, or at least to accede silently to laetrile’s apparent benefit to his patient. “Words can kill,”¹⁹ he admonished.

Thomas Percival, “the most influential” of Anglo-American medical ethicists,²⁰ would have embraced deceit in both cases. In his 1803 treatise, *Medical Ethics: A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons*,²¹ Percival

cautioned physicians against providing patients with any negative information:

For the physician should be the minister of hope and comfort to the sick; that by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which rob the philosopher of fortitude, and the Christian consolation.²²

In 1847, the AMA's first code of ethics incorporated Percival's mandate, admonishing the physician to adhere to a "sacred duty" "to avoid all things which have a tendency to discourage the patient and to depress his spirits."²³ Moreover, the AMA explicitly advised against allowing the patient any voice in diagnosis and treatment: "[P]hysicians should unite in tenderness with firmness, and condescension with authority, [so] as to inspire the minds of their patients with gratitude, respect, and confidence."²⁴

The rise of the informed consent doctrine signaled the decline of Percival's ideal. First articulated in 1957 by the California court of appeals,²⁵ the doctrine subsequently found favor in the courts of all states²⁶ and the AMA's writings on ethics.²⁷ In its most common formulation, the doctrine requires disclosure to the patient of the benefits and risks of and alternatives to any prescribed treatment.²⁸

Recent research regarding the biological and psychological workings of the placebo effect provide reason both to reevaluate the informed consent doctrine and to revisit Percival's writings. Researchers have discovered placebos to be statistically effective in treating a variety of ailments, including hair loss, asthma, allergies, and pain.²⁹ And the physician's role is critical to any positive placebo effect. Simply put, when physicians communicate hope, patients are more likely to respond to treatment.³⁰ Of course, informing the patient that he or she is receiving a placebo jeopardizes any potential placebo-driven benefit.³¹ As the editorialist in a recent issue of the *Journal of the American Medical Association* expressed in summarizing the research, "it's not

simply mind over matter, but it is clear that mind matters.”³²

This article explores the intersection of medical ethics, the informed consent doctrine, and the placebo effect. Part I presents an overview of the evolution of medical ethical precepts regarding the physician’s obligation to reveal treatment information to patients. This part also reviews the development of the informed consent doctrine. Part II presents and evaluates recent scientific research regarding the placebo effect.

Part III states the case for Percival’s revenge by posing a hypothesis that frames Percival’s ethic in the narrowest terms. The duty of obtaining a patient’s informed consent must yield when the predictable effect of a placebo exceeds that of all other treatments. Examples might include end-stage cancer and AIDS treatment. In these cases, the reasonably prudent physician would choose placebo treatment. Yet, if the physician informs a patient of the placebo, treatment may be compromised. And because other treatments are ineffective, the patient suffers no harm if the placebo also proves ineffectual.

Part III also rejects the hypothesis. The use of placebo will compromise medicine by introducing doubt into all treatment. Good news, in effect, may hide bad news. A physician’s statement, “Here, take this medication, it should have you up and about in no time,” may lead the patient to conclude, “Oh, no, I’m dying.” Ultimately, conveying hope over all else, Percival’s ideal, will result in communicating doubt.

Part IV concludes the article by revisiting the doctrine of informed consent. The rejection of the hypothesis also informs the justification for the doctrine. While most have defended the doctrine of informed consent with arguments from patient autonomy, this article supports the doctrine with arguments from beneficence. Physician veracity, apart from catalyzing patient

autonomy, serves the patient by sustaining the therapeutic relationship. Percival supported informing the patient when the “beneficial nature” of disclosure could be assured. It may be a small measure of revenge, but it at least raises Percival’s notion of “professional duty” to the level of the “obligation of veracity.”³³

I. MEDICAL ETHICS AND THE RISE OF INFORMED CONSENT: OF TRUTH AND TREATMENT

Medical ethicists from Hippocrates³⁴ to the drafters of American Medical Association’s first Code of Medical Ethics³⁵ and the Declaration of Geneva of the World Medical Association,³⁶ have consistently failed to address the question whether a physician is obliged to tell her patient the truth about her treatment.³⁷ The authors of these works urge promoting the patient’s welfare, but never mention the virtue of veracity.³⁸

Until recently, practitioners evidenced a similar indifference to veracity. In 1961, for example, a study revealed that nearly 90% of physicians did not tell their cancer patients the truth about their diagnosis and prognosis.³⁹ Within two decades, however, physician attitudes, if not codes of ethics,⁴⁰ changed. By 1979 almost all physicians reported that they did tell their cancer patients the truth.⁴¹

That two-decade transformation reflects a “protracted ideological struggle”⁴² within the profession. Veracity’s victory came only when courts, through the creation of the doctrine of informed consent, forced clinicians to embrace the topic.⁴³

A. Medical Ethics

1. Hippocrates and the ancients.

Hippocrates’ writings⁴⁴ constitute the “first Western writings about medical professional

conduct.”⁴⁵ Written between 430 and 330 B.C.,⁴⁶ the works, probably the remnants of the Hippocratic school of medicine’s library,⁴⁷ “remain among the most influential” writings on medical ethics.⁴⁸

The Hippocratic Oath makes no mention of a physician’s obligation to seek a patient’s informed consent. The only reference to the issue in the Hippocratic Corpus advises against any conversation:

Perform [these] duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient’s future or present condition.⁴⁹

Conversation between physician and patient would impede the physician in carrying out the mission of gaining the patient’s confidence to ensure compliance with treatment orders.⁵⁰

Moreover, Hippocrates warned that any prognostication could harm the patient: “For many patients . . . have taken a turn for the worse . . . by the declaration . . . of what is present, or by the forecast of what is to come.”⁵¹

Although occasionally criticized, this Hippocratic ideal persisted, at times playing an even more important role in medical practice than it did in ancient Greece. In Medieval times, for example, the notion of a noncommunicative physician and patient relationship gained religious significance. Viewed as “the minister of nature,”⁵² the physician had taken up a sacred calling:

The . . . intimate relationship between physicians, patients, and their God made any critical questioning of doctors’ practices difficult. During the Age of Faith such an encounter came close to blasphemy. Thus, not only would patients find it difficult to question their . . . physicians but the latter, being appointed by God, also would disdain explaining themselves and their practices.⁵³

2. Thomas Percival.

The post-Medieval history of the content of conversations between physicians and their patients might be characterized as a triumph of hope over truth. The English physician Thomas Percival was the chief proponent of this ethic.

Percival was a staff physician at the Manchester Infirmary in England in the late 1700s.⁵⁴ When an influx of typhus cases led the hospital to increase staff, the incumbent physicians resigned. The physicians then asked Percival to draft a code of professional conduct to be used in resolving the dispute.⁵⁵ The result was *Medical Ethics: A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons*, “the most influential document in Anglo-American medical ethics.”⁵⁶

From the outset, the work’s most controversial provision was Percival’s command that the physician “should be the minister of hope and comfort” who shapes conversations with patients to “counteract the depressing influence of [the patient’s] maladies.”⁵⁷ Percival submitted an early draft of his work to Rev. Thomas Gisborne, who was then writing his most famous work, *Enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain Resulting from Their Respective Stations, Professions, and Employment*.⁵⁸ Gisborne urged Percival to limit the obligation to convey hope only “as far as truth and sincerity will admit.”⁵⁹ Gisborne added:

[T]here are few professional temptations to which medical men are more liable, and frequently from the very best principles, than that of unintentionally using language to the patient and his friends, more encouraging than sincerity would vindicate, on cool reflection; it may be scrupulous to guard against such an error.⁶⁰

Gisborne also addressed this issue in *Enquiry into the Duties of Men*:

Humanity, we admit, and the welfare of the sick man commonly require, that his drooping spirits should be revived by every encouragement and hope, which can honestly be suggested to him. But truth and conscience forbid the physician to cheer him by giving promises or raising expectations, which are known or intended to be delusive.⁶¹

Percival conceded that some noted ethical authorities would side with Gisborne.⁶² St. Augustine, for example, in Percival's words, "would not utter a lie, though he were assured of gaining Heaven by it."⁶³ Yet, Percival contended that a lie consists only of a "*criminal* breach of the truth."⁶⁴ When the speaker is motivated not by a desire to deceive, but by some good, the utterance is not a lie: "[F]alsehood may lose the essence of lying, and become even praiseworthy, when the adherence to truth is incompatible with the practice of some other virtue of still higher obligation."⁶⁵

Percival cited Puffendorf in support of his position. In *Law of Nature and Nations* Puffendorf asserted that one need not speak truthfully when doing so would injure the listener. This is particularly so when "comforting the afflicted."⁶⁶ Similarly, contended Percival, Francis Hutcheson, who otherwise "abhorred the least appearance of deceit,"⁶⁷ would countenance a physician's expression of hope to a patient. "We must not do evil that a good may come of it."⁶⁸

Percival summarized his position by characterizing the obligation of veracity as a "relative duty," which must be balanced against a "contending obligation[]" of "professional duty."⁶⁹ The truth must occasionally yield to a patient's greater needs:

To a patient, therefore, perhaps the father of a numerous family, or one whose life is of the highest importance to community, who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated; because its beneficial nature being reversed, it would be deeply injurious to himself, to his family, and to the public. And he has the strongest claim, from the trust reposed in his physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him.⁷⁰

Percival concluded this discourse by recounting what he believed to be conduct reflecting the proper balance between hopefulness and candor:

Lady Russel's only son, Wriothesly, Duke of Bedford, died of small-pox in

May 1711, in the 31st year of his age. To this affliction succeeded, in Nov. 1711, the loss of her daughter, the Duchess of Rutland, who died in child-bed. Lady Russell, after seeing her in the coffin, went to her other daughter, ... from whom it was necessary to conceal her grief, she being at that time child-bed likewise; therefore she assumed a cheerful air, and with astonishing resolution agreeable to truth, answered her anxious daughter's entreaties with these words: 'I have seen your sister out of bed today.'

Rather than resolving the issue definitively, Percival chose to leave each reader to reach an independent conclusion, perhaps assisted by consulting the authors Percival had discussed.⁷¹ The conflict, Percival suggested was not between the physician's veracity and the patient's autonomy. Rather, the physician must wrestle with whether occasionally to compromise his or her veracity for the good of the patient. Lisbeth Haakonssen has summarized Percival's portrayal of the dilemma:

Not telling the truth to the patient was a great personal sacrifice which the physician should only allow in a real emergency, for it was also his duty to guard himself against the moral injuries which could occur to his character by frequent violations of 'the native love of truth.'⁷²

This characterization of the predicament of medical ethics as singular to the province of the physician and unconnected to the patient would prove influential.

3. *The AMA*

The AMA established a Code of ethics at its first meeting in 1847.⁷³ Eleven years later, it established the Committee on Ethics, later renamed the Council on Ethical and Judicial Affairs (CEJA) to implement the ethics code.⁷⁴ In some cases, what one has granted, the other has taken away.

The 1857 Code stands as a testament to Percival's influence. Indeed, as Isaac Hays, one of the Code's chief authors, noted in a preface to the Code, the AMA lifted significant portions directly from *Medical Ethics*.⁷⁵

On examining a great number of codes of ethics adopted by different societies in the United States, it was found that they were all based on that by Dr. Percival, and that the phrases of this writer were preserved, to a considerable extent, in all of them. Believing that language which had been so often examined and adopted, must possess the greatest merits for such a document as the present, clearness and precision, and having no ambition for the honours of authorship, the Committee which prepared this code have followed a similar course, and have carefully preserved the words of Percival wherever they convey the precepts it is wished to inculcate.⁷⁶

Although Percival's influence on some aspects of the Code may be debatable,⁷⁷ the imprint of his mandate to value "professional duty" over "veracity" is unmistakable. For example, the opening passage decrees that physicians should "so unite *tenderness* with *firmness*, and *condescension* with *authority*, as to inspire the minds of their patients with gratitude, respect, and confidence."⁷⁸

The AMA embraced Percival's ideal even more clearly in the Code's fourth passage:

[T]he physician should be the minister of hope and comfort to the sick; that, by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned, in their last moments. The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.⁷⁹

When these provisions apparently proved controversial,⁸⁰ in its first revision of the Code in 1903, the AMA simply deleted any reference to the physician's duty to inform patients. In the next five decades, the AMA twice amended the Code to delete controversial provisions regarding the physician-patient relationship.⁸¹

By 1957, the Code, renamed the *Principles of Medical Ethics*, had been reduced from 48 sections to 10 "principles."⁸² It conflated all mandates regarding the physician-patient relationship into a single sentence: "The principal objective of the medical profession is to render service to

humanity with full respect for both the dignity of man and the rights of patients.”⁸³

Despite the radical revision, CEJA Council maintained that it had retained the essence of Percival’s code:

In justifying the change from the original Percivalean format, the Council on Constitution and Bylaws remarked that “every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated.”⁸⁴

CEJA entered the vacuum created by the reduction of the *Principles* text from fifty six hundred words to five hundred.⁸⁵ The entry, however, may not have been voluntary. To comply with emerging informed consent case law,⁸⁶ CEJA instructed physicians to disclose to the patient “all facts relevant to” medical procedures.⁸⁷ To comply with recent Congressional mandates,⁸⁸ CEJA advised obtaining “voluntary consent” to the use of new drugs or procedures and participation in clinical investigations.⁸⁹

In 1980, largely in response to Justice Department antitrust allegations regarding the *Principles*’ contract and advertising provisions,⁹⁰ the AMA halved the document to 250 words.⁹¹ Three sentences addressed patient rights. Principle I directed physicians to respect “human dignity.” Principle II directed physicians to “deal honestly with patients.” Principle IV commanded physicians to “respect the rights of patients.” Perhaps in an elliptical reference to the emerging law of informed consent, Principle III commanded that a physician “respect the law.”⁹²

Although the 1980 *Principles* did not explicitly broach the subject, for the first time in 1981 CEJA addressed informed consent. CEJA did not describe informed consent as a policy either it or the AMA embraced. Rather, it expressed its position as an acquiescence to a “social policy” which “does not accept the paternalistic view that the physician may remain silent because

divulgence might prompt the patient to forego needed therapy.”⁹³ That policy, CEJA noted, must yield “when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated.”⁹⁴ In other words, the physician determines whether to implement the social policy.

The AMA has not updated the 1980 *Principles*.⁹⁵ CEJA, however, has had occasion to revisit the subject. In 1992, and updated in 1993, for example, CEJA issued its *Fundamental Elements of the Patient-Physician Relationship*. While still abstaining from an unequivocal embrace of “informed consent,” CEJA recognized that “[t]he patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.”⁹⁶

Patients may, of course, “accept or refuse” medical treatment,⁹⁷ but those decisions are not to be free of physician influence. Although CEJA notes that patients have “the right to make decisions regarding the health care that is recommended by” a physician,⁹⁸ CEJA does not contemplate that patients might consider treatment without a physician’s input. Indeed, “[p]atients should receive guidance from physicians as to the optimal course of action.”⁹⁹

Moreover, and betraying Percival’s continued influence, the *Elements* do not root in autonomy the patient’s right to receive information and participate in the decision making process. Rather, patients should collaborate in their treatment because doing so will benefit their “health and well-being.”¹⁰⁰ All physician duties follow from the duty of beneficence.¹⁰¹ But, what if collaboration were proven, in some circumstances, to defeat the effectiveness of the treatment?

4. Summary

Perhaps Samuel Johnson’s sentiments two centuries ago best portray the views of

Percival's critics:

I deny the lawfulness of telling a lie to a sick man for fear of alarming him. You have no business with consequences; you are to tell the truth. Besides, you are not sure what effects your telling him that he is in danger may have. It may bring his distemper to a crisis, and that may cure him. Of all lying, I have the greatest abhorrence of this, because I believe it has been frequently practised on myself.¹⁰²

This article raises a series of questions for those sympathetic to Mr. Johnson's views.

What if the effects are known? If the probable outcome of the lie (the placebo) exceeds that of the truth (established treatment), should physicians enter the business of assessing consequences?

What are the ramifications of eschewing consequences?

B. The Informed Consent Doctrine

1. In General: The Revolution of Patient Self-Determination

The emergence of the informed consent doctrine would have heartened Samuel Johnson as much as it would have disturbed Thomas Percival. Simply put, the doctrine represents a triumph of patient self-determination over the paternalistic concerns of physicians.¹⁰³

The concept of informed consent arguably first appeared in a judicial opinion in 1767 in the English decision of *Slater v. Baker and Stapelton*.¹⁰⁴ The patient had visited the defendant physicians to have bandages removed from his leg. Instead, and over the patient's objection, the physicians refractured, set, and braced the leg in what was evidently an experimental device.¹⁰⁵ In upholding the patient's breach of contract claim, the court's language foreshadowed both medical malpractice and informed consent tort theories: "[I]ndeed, it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation."¹⁰⁶

Although there were precursors that linked consent and patient autonomy,¹⁰⁷ the most

celebrated language from early United States cases appeared in Justice Benjamin Cardozo's opinion in the 1914 case of *Schloendorff v. Society of New York Hospitals*.¹⁰⁸ In upholding a patient's assault claim against a hospital for unauthorized surgery, Cardozo stated:

In the case at hand, the wrong is not merely negligence. It is trespass. 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 commits an assault, for which he is liable in damages.¹⁰⁹

During the next 40 years, most United States courts followed Cardozo's lead in grounding actions regarding the lack of patient consent in trespass or assault. These courts focused on whether patients had consented to the challenged physician actions. Few, however, addressed what information, if any, the physician should provide the patient to ensure that the consent was knowing. Or, as Jay Katz has put it, these decisions "neither invited nor required a sophisticated examination of the relationship between disclosure and consent, on the one hand, and self-determination, on the other."¹¹⁰

In 1957, in *Salgo v. University Board of Trustees*,¹¹¹ the California Court of Appeals embarked on this examination, if not in the depth Katz would have liked.¹¹² In any event, the court's opinion signaled a change in both the theory of the patient's recovery and the physician's concomitant duty to that patient.

In *Salgo*, the patient suffered injuries during a diagnostic procedure. The patient alleged that his physician had not provided him with any information about the procedure, including the risks associated with it. In accepting the patient's novel theory of a negligent failure to provide information,¹¹³ the trial court instructed the jury that the physician must disclose to the patient "all the facts which mutually affect his rights and interests and of the surgical risk, hazard, and danger, if any."¹¹⁴

The court of appeals found the trial court's statement of the duty to be overly broad. It reversed the decision and advised the trial court of the content of the instruction on retrial:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce the patient's consent.¹¹⁵

The court was careful, however, not to measure the needed disclosure solely according to the patient's wishes, a position close to that which Katz would later urge. Instead, the court called for balancing the patient's wishes with the physician's judgment. In so doing, the court both coined the phrase "informed consent," and gave continued life to Percival's plea for basing all medical judgments on the physician's determination of the best course of conduct for insuring the patient's ultimate recovery.

[T]he physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.¹¹⁶

In *Salgo*, the patient premised his claim on negligence. And the reference in the court of appeal's opinion to a duty appears to ground the newly recognized doctrine of informed consent in negligence. Yet, the court cited only assault cases, including *Schloendorff*, in support of finding this duty.¹¹⁷ Apparently for this reason, subsequent cases cited *Salgo*, but grounded the cause of action in the tort of assault.¹¹⁸

In the two decades following *Salgo*'s invocation of the phrase "informed consent," the courts of all states embraced the doctrine.¹¹⁹ In the process, courts took up two related questions that *Salgo* raised, but did not resolve. First, courts wrestled with whether to ground the cause of action in battery or negligence, resulting in a line of cases endorsing each theory, but both premised on patient autonomy.¹²⁰ Eventually, pragmatics dictated a negligence based theory.¹²¹ Battery as easily as negligence can support actions concerning bodily invasion that the patient claims he or she would have refused if the physician had disclosed all relevant information. Only negligence, however, can support a claim concerning a decision to forego treatment.¹²²

Although this formalization of the informed consent doctrine surely would have troubled Percival, the decision to ground the theory in negligence prescribed a resolution to a second question, which just as surely would have pleased him. In 1960, in *Natanson v. Kline*,¹²³ the Kansas Supreme Court issued the nation's first explicitly negligence-based informed consent decision.¹²⁴ Premising informed consent on negligence influenced the court's decision regarding the standard by which to measure the sufficiency of the disclosure. The failure to disclose the requisite information produced malpractice liability. In accordance with malpractice doctrine, "[t]he expert testimony of a medical witness is required to establish whether such disclosures are in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances."¹²⁵

The result in *Natanson* surely represented another blow to Percival's ethic. But, allowing physicians to determine the sufficiency of the disclosure at least mitigated the damage that recognizing patient self-determination had visited upon the province of physicians.

The paternalism inherent in determining from the physician's perspective what the patient

needs to know was threatened in 1972 by District of Columbia Circuit Court decision in *Canterbury v. Spence*.¹²⁶ In concluding that the failure to reveal a “risk of paralysis” from a surgical procedure constituted “a prima facie case of violation of the physician's duty to disclose,”¹²⁷ the court rejected the majority rule “framed with reference to prevailing fashion within the medical profession.”¹²⁸

We cannot gloss over the inconsistency between reliance on a general practice respecting divulgence and, on the other hand, realization that the myriad of variables among patients makes each case so different that its omission can rationally be justified only by the effect of its individual circumstances. Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.¹²⁹

Canterbury's threat to paternalism was short lived. In the early 1970s, in response to physician efforts¹³⁰ to curb a “medical malpractice crisis,”¹³¹ state legislatures began to codify the reasonable physician centered standard. By the early 1980s, 30 states had done so. Physicians might be obligated to inform their patients of risks of treatment, but they could decide just what information about those risks their patients might need to know.¹³²

The rise of the informed consent doctrine, then, signaled the decline, but perhaps not the demise of Percival's ideal. In circumstances of “contending obligations of veracity and professional duty” about which Percival warned his colleagues,¹³³ the law might enforce veracity's obligation to disclose. But, professional duty demarcates what is disclosed.

2. The Exceptions: of Paternalism and Self Determination

Additional aspects of the doctrine of informed consent leave room for professional duty to prevail over a patient's interest in autonomous decision-making. Certainly, in cases of emergency

or incompetent patients, consent cannot be obtained. Here, veracity cannot compete with professional duty.

A patient may waive the right to an informed consent.¹³⁴ In effect, the patient can, if properly informed, relinquish the right to be informed. In an ironic twist, the patient can reinstitute Percival's ideal.

Most applicable to Percivalian ideals is the therapeutic exception. Simply put, the physician may withhold information when it "poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view."¹³⁵ As the *Canterbury* court recognized, the exception can threaten the rule:

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. 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. Nor does the privilege contemplate operation save where the patient's reaction to risk information, as reasonably foreseen by the physician, is menacing.¹³⁶

Even if carefully circumscribed, Percival would find some hope for paternalism in this exception. The therapeutic exception is premised on a prediction of the effect of disclosure. In those circumstances, the doctrine commands that the physician do "business with consequences," and not with "tell[ing] the truth."¹³⁷

Placebo therapy is also about "consequences." Common use of placebos would, of course, extend the "business of consequences" beyond the therapeutic exception as articulated by the *Canterbury* court. The theory of use is not that the patient cannot cope with disclosure of risks, but that these "lies that heal"¹³⁸ can improve outcomes in a number of ailments. In the words of a

recent article in the *New York Times*, “Placebos aren’t real medicines, but they can often help patients heal. So why not exploit their power?”¹³⁹

II. THE PLACEBO EFFECT: OF DECEPTION AND TREATMENT

[U]ntil Recently, the history of medical treatment is essentially the history of the placebo effect.¹⁴⁰

A. Origins

“Placebo” is Latin for “I shall please.”¹⁴¹ People in the middle ages used the word to refer to “professional mourners who sang at funeral masses.”¹⁴² The term is perhaps best known from its role as the opening phrase of the Catholic Vespers for the Dead.¹⁴³

“Placebo” entered the medical vocabulary in 1811 with its publication in *Hooper’s Medical Dictionary*.¹⁴⁴ The dictionary defined the term in unflattering fashion, characterizing “placebo” as “an epithet given to any medicine adapted more to please than to benefit the patient.”¹⁴⁵

The publication of *Hooper’s* also coincided with what Michel Foucault has termed “the birth of the clinic.”¹⁴⁶ Prior to that date, medicine still followed the Galenic tradition, which considered disease to reflect an imbalance of the body’s internal fluids and forces. Around 1811, medicine began to embrace the Cartesian dualism, which separated body from mind. As a result, medicine could treat the body’s maladies, and, at least in theory, ignore issues of the “harmony linking the microcosmic bodies with the divinely ordered macrocosm.”¹⁴⁷

This is not to say that prescientific medicine was ineffective. But, most of its effect was probably due to placebo effect.¹⁴⁸ For example, Galen’s *Pharmacopoeia* was the dominant medical text during the millennium and a half that preceded the nineteenth century.¹⁴⁹ Galen, physician to Marcus Aurelius, compiled a “recipe” book originally containing approximately 130

antidotes and medicines. Toward the end of its use, the text offered 820 remedies.¹⁵⁰ Yet, Galen himself conceded that the effect of the treatments was influenced by the patients' attitude: "He cures most successfully in whom the people have the most confidence."¹⁵¹

The birth of the "clinic" propelled physicians to attempt to distinguish these "confidence" effects from the asserted effects of treatment. And research soon demonstrated that the scientific revolution in medicine had improved outcomes.¹⁵² But, physicians were slow to abandon the "confidence." At the turn of the twentieth century, Harvard physician Richard C. Cabot, author of both the classic teaching reference, *Clinicopathological Conference*, and his manifesto against lying in medical treatment, *The Use of Truth and Falsehood in Medicine: An Experimental Study*,¹⁵³ contended that his colleagues handed out placebos "by the bushels."¹⁵⁴

Those physicians may have had good reason for their actions. By the middle of the twentieth century, another Harvard researcher, Henry K. Beecher, published one of the earliest broad-based studies of placebo effect.¹⁵⁵ Beecher concluded that 30% to 40% of any group, treated for nearly any ailment, would respond to placebo.¹⁵⁶ Not only had science failed to displace "confidence," it had begun to confirm the utility of confidence.

B. The Data

[T]he effectiveness of placebos ranges anywhere from 1 percent to 100 percent, depending on the conditions of the trial. Indeed, placebos have proven effective in maladies that range all the way from depression and congestive heart failure to gastric ulcers and angina pectoris.¹⁵⁷

Much of the knowledge of placebo effect has derived from what have become known as "blind"-- only the patient is unaware of the placebo-- and "double-blind" -- patient and physician are both unaware -- controlled studies designed to measure the efficacy of a variety of medical substances. The first two, in 1908¹⁵⁸ and 1912,¹⁵⁹ were studies of the effect of alcohol and other

substances on fatigue. The placebo, too, proved efficacious.

Perhaps spurred by these early studies, two decades later, Harry Gold formalized the double-blind study design. In so doing, he set the stage for scientific confirmation of the placebo effect. Commencing in 1935 and culminating in 1950 with the publication of the first paper to term the procedure a “double-blind” method, Gold studied the effect of ether¹⁶⁰ and substances used to treat angina¹⁶¹ by comparing each to a placebo.

Buoyed by his findings, Gold began to champion his double-blind use of placebos as the model for any investigation of the effect of treatment.¹⁶² Within a few decades, he had apparently convinced the medical research community. By the 1960s, the National Institutes of Health began to require a double-blind placebo study design as a condition to receiving any funding. The Food and Drug Administration (FDA) followed suit in the 1970s for drug approvals. And by the 1980s, scientific journals began limiting publication to double-blind studies.¹⁶³ As a result, “researchers have finally come to review and to respect the evidence that placebos really work.”¹⁶⁴

The effect of placebos is most apparent in the treatment of pain. In 1985, for example, Frederick J. Evans reviewed the existing double-blind placebo/morphine studies and concluded that placebos are, on average, 56% as effective as injected morphine “in reducing severe clinical pains of various kinds.”¹⁶⁵ Moreover, Evans concluded that the placebo response is a near-constant in treating many conditions. Placebos are 54% to 56% as effective as aspirin, Darvon, and codeine in reducing pain. Placebos are 58% as effective as nonpharmacological treatments for insomnia and 59% to 62% as effective as psychotropic drugs in treating depression.¹⁶⁶ “Thus,” concluded Evans, “it appears that placebo is about 55%-60% as effective as active medications, irrespective of the potency of these active medications.”¹⁶⁷

Other studies have reinforced Evans' findings regarding placebo-induced pain relief. A 1984 study, for example, concluded that a placebo is the equivalent of approximately eight milligrams of morphine.¹⁶⁸

Placebos also are effective when compared against a control group that receives nothing to alleviate pain. Several studies have found a significant placebo effect on patient's rating of pain according to an intensity scale.¹⁶⁹

Researchers also have documented placebo effects in psychotherapy. In general, placebos are 30% to 40% as effective as conventional medications in treating moderate to severe depression.¹⁷⁰ In particular, placebos are 59% as effective as tricyclic antidepressants and 62% as effective as lithium.¹⁷¹

The study of treatments for angina pectoris -- unspecified chest pain -- has been particularly revealing. In 1979, Herbert Benson and David McCallie undertook a study because, although a number of treatments initially believed to be effective were later proven ineffective, "the diagnostic criteria for angina pectoris and the evaluation of its severity [had] not changed appreciably in 200 years."¹⁷² Thus, the ailment offered a particularly useful opportunity to investigate "the contribution of the placebo effect" in treatment.¹⁷³

Benson and McCallie commenced their investigation by summarizing the history of the effectiveness of angina treatments. Upon introduction, "enthusiasts" report astonishing benefits. These claims are followed by controlled studies conducted by "skeptics," which invariably conclude that the enthusiasts have exaggerated the utility of the treatment. "Quantitatively, the pattern is consistent: the initial 70 to 90 per cent effectiveness in the enthusiasts' reports decreases to 30 to 40 per cent 'base-line' placebo effectiveness in the skeptics' reports."¹⁷⁴ As

French physician Armand Trousseau said in the nineteenth century, “You should treat as many patients as possible with the new drugs while they still have the power to heal.”¹⁷⁵ But, even a physiologically inactive “drug” apparently has a residual placebo impact after the other healing powers have worn off.

Benson and McCallie confirmed this pattern when examining the effectiveness of methyl xanthines – supposed coronary vasodilators. Early reports estimated that as many as 80% of angina sufferers benefitted from taking xanthines. Subsequent studies cast doubt on these claims. Researchers conducted a two and a half year, single-blind study that tested two varieties of xanthines together with 11 other drugs. “[I]n general, placebo pills were the best therapy, since approximately 37 per cent of the patients showed ‘moderate to great’ improvement.”¹⁷⁶

An investigation of a once-popular surgical technique yielded nearly identical results. In the 1950s, many physicians treated angina with ligation of the internal mammary artery.¹⁷⁷ Despite claims of up to a 91% success rate, in the late 1950s, two skeptics conducted separate double-blind tests in which half the patients received skin incision, but not artery ligation. In both studies, the placebo surgery proved equally effective as the ligation. And, again, the overall rate of improvement with the placebo was 37%.¹⁷⁸

Recent years have witnessed a number of placebo surgery studies. Of course, the informed consent doctrine has transformed the procedure. In the typical study, patients are assigned at random either to the actual surgery group or the placebo group. They are told that they stand a 50% chance of receiving the placebo surgery. Despite the disclosure, the results have been comparable to the pure double-blind angina studies.

For example, in 1994, Bruce Moseley, a Texas surgeon and team physician for the NBA’s

Houston Rockets, conducted a double-blind pilot study of arthroscopic knee surgery.¹⁷⁹ Of the 10 patients, five received surgery while the other five received only small incisions on skin of their knees. All experienced improvement. At least one placebo patient remains a satisfied customer, despite knowing that he received the placebo.

The surgery was two years ago and the knee never has bothered me since. 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!'¹⁸⁰

A similar study of Parkinson's surgery has proven controversial. In the early 1990s, Dr. Curt Freed of the University of Colorado sought to study the effectiveness of treating Parkinson's disease with injections into the brain of fetal tissue cells. In a funding request to the National Institutes of Health, he proposed a controlled study in which half the patients would have dime-sized holes drilled into their heads, but would not receive the injections.¹⁸¹ Not only did NIH approve the proposal, but it applauded Curt's efforts to shirk the surgery/drug "double standard" by which pharmaceuticals but not surgical procedures have been subjected to placebo studies. "Too many surgeries are done on the basis of anecdotal evidence and not put to the same sort of rigorous tests that drug therapies are," reported the chair of the NIH committee which reviewed the proposal.¹⁸²

The placebos, though less so than the injections, proved effective. Said one placebo patient who reported improvements in her condition, "I really thought I had [received the treatment]. I thought I couldn't be fooled. But I was."¹⁸³ An NIH oversight committee later withdrew approval for the study when it became concerned about "adverse events," including deaths, in the patients who had received the injections.¹⁸⁴

These studies illustrate another aspect of the placebo use: the effectiveness of placebos tends to vary with the degree of medical intervention. “The bigger and more dramatic the patient perceives the intervention to be, the bigger the placebo effect. Big pills have more than small pills, injections have more than pills and surgery has the most of all.”¹⁸⁵

Patients need a “reason to believe”¹⁸⁶ in the placebo. The more impressive the reason, the greater the belief. The greater the belief, the greater the placebo effect.

C. Explanations

[T]he demonstrable, if unexplained, therapeutic success of placebos means that the question today must be reframed not as whether placebos work, but *how* they work.¹⁸⁷

1. Endorphins

Walter A. Brown, a professor of psychiatry at Brown University, has observed that, at least in relieving pain, not only do placebos work, but they work the way conventional treatments work:

[W]hen placebos are given for pain management, the course of pain relief follows what you would get with an active drug. The peak relief comes about an hour after it’s administered, as it does with the real drug, and so on. If placebo analgesia was the equivalent of giving nothing, you’d expect a more random pattern.¹⁸⁸

Research over the last several decades has provided an explanation for this phenomenon. In the 1970s, a number of scientists discovered the existence of endorphins.¹⁸⁹ “Chemically similar to opium-derived narcotics, endorphins attach themselves to the same receptor sites in the brain as morphine and thus appear to be the brain’s own natural painkillers.”¹⁹⁰ Placebos appear to produce endorphins. When study subjects receiving placebos are given naloxone, a substance that blocks opiate receptors, the subjects report increased pain.¹⁹¹

A 1978 study of postoperative dental pain demonstrated this effect most clearly. After the

procedure, all patients were given a placebo. For a second treatment, the patients randomly received either another placebo or naloxone. The naloxone increased the pain experienced by those who had responded to the first placebo but not by those who had not responded to the placebo.¹⁹²

Several studies have supported these indirect findings with direct findings of production opioids – natural opium-like substances – in response to placebos. For example, in a 1990 study researchers sampled the cerebrospinal fluid of chronic pain sufferers who had responded to placebos. They discovered higher levels of opioids. “This is the first direct evidence that a [cerebrospinal fluid] opioid is correlated with placebo pain relief in chronic pain patients,” the researchers reported.¹⁹³ A 1999 study discovered opioid production in the hands and feet in response to pain application. As the researchers concluded, “[t]his suggests that a highly organized and somatotopic network of endogenous opioids links expectation, attention, and body schema.”¹⁹⁴

2. Conditioned Response

Although the production of endorphins can explain placebo response in pain reduction, it does not address placebo responses in other ailments. For example, one study eliminated warts with an inert, painted-on dye. Another treated colitis patients with a placebo and discovered that 50% experienced a decrease in inflammation in their intestines.¹⁹⁵

A 1975 study provided the first evidence of an explanation for these phenomena. Robert Ader and Nicholas Cohen conducted a study of placebo response in rats. He and his coworkers supplied rats with saccharin-flavored water and also injected them with an immunosuppressive and nausea-inducing drug. The drug caused the rates to die at high rates. Yet, when Ader and

Cohen ceased the injections, the rats continued to die at high rates.¹⁹⁶

A similar 1990 study in humans paired a sham analgesic cream with pain caused by an electrical stimulus. The researchers applied the stimulus to cause pain and then reduced the stimulus, applied the cream, and told the subjects that the cream would reduce the pain. In successive trials, the researchers applied the cream while maintaining the electrical stimulus at its original level. The subjects reported that the pain had decreased.¹⁹⁷

Similarly, cancer patients who respond to placebos also display the side effects of which they are warned.¹⁹⁸ A 1950 study, one of the first experimental placebo studies, revealed that subject who ingested a substance that produced gastric acid, exhibited the same reaction after ingesting a placebo.¹⁹⁹

As David Spiegel recently observed in an editorial in the *Journal of the American Medical Association*, “it is clear that mind matters.”²⁰⁰

3. The unexplained: of mind over matter

Speigel qualified his admonition by asserting that placebo effect “is not simply mind over matter.”²⁰¹ Yet, the study to which he referred suggested just that. Observing that “[a] growing amount of literature suggests that addressing patients’ psychological needs produces both psychological and physical benefits,” the researchers examined the relationship between expressive writing asthma and arthritis symptoms.²⁰² The experimental group wrote for 20 minutes on three consecutive days about “the most stressful experience they had ever undergone.”²⁰³ The control group wrote about their plans for the day. The experimental group experienced a statistically significant, clinically verifiable, improvement over the control group.²⁰⁴ As the authors put it, “the medical community has come to recognize the importance of

psychological and social factors in preventing and treating illness.”²⁰⁵

Those factors can lead to results more significant than recovery from a chronic ailment. New York City, for example, saw its death rate drop in the few days before the end of the last millennium and increase by 50% over the prior year in the week after New Year’s day, 2000.²⁰⁶ Said the associate director of the National Institute on Aging: “It’s pretty well established that people who are seriously ill will hang on to reach significant events, whether they be birthdays, anniversaries or religious holidays. In this case, making it into the next century or millennium certainly counts as that.”²⁰⁷

Researchers trying to account for phenomena such as these seek to construct a new model of medicine which may have consequences for both ethics and law.

By the time we’ve reached a model that truly can account for [these occurrences], then it no longer is “just” a neurobiological model; it’s something more than that. It’s something that integrates, that blurs what we consider to be the self “inside” and the self “outside.” And when a way of thinking like that is established, we won’t be just doing neurobiology. We will be doing something new, something integrative that we can’t yet fully imagine.²⁰⁸

D. The State of the Art of Deception

Placebo response varies with the sum of the deception. For example, in double-blind studies, where both patient and physician are aware of the possibility of placebo use, placebos are least effective. Placebos are more effective in single-blind studies where only the physician is aware of the possibility of deception. Placebos are most effective “in uncontrolled clinical reports of a treatment believed to be effective but subsequently shown to be ineffective or placebo.”²⁰⁹ In effect, the response is best if both physicians and patients are completely deceived.

Short of this wholesale circumvention of FDA and Congressional mandates for

pharmaceutical disclosures, we cannot hope routinely to deceive physicians about placebos. We may, however, be able to raise their expectations about newly issued pharmaceuticals.²¹⁰ And, in any event, placebo effect will always be maximized if physicians do not reveal to patients the possibility that they will receive a placebo.

III. THE HYPOTHESIS POSED: OF DECEPTION AND TREATMENT

A. Of Deception as Treatment

In recent years, psychiatrist Walter A. Brown has been urging a model for the use of placebos. As summarized in a *New York Times Magazine* story, the physician accompanies the placebo administration with duplicitous language carefully couched to disclaim and endorse the artifice simultaneously:

Mrs. Jones, the type of depression you have has been treated in the past with either antidepressant medicine or psychotherapy, one of 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.²¹¹

Brown's model attempts to balance the mandates of informed consent doctrine against the revelations of the placebo research. He proposes that physicians disclose that the supplied pills "do not contain any drug," yet does not propose informing the patient that the pill also does not contain any other active ingredient, such as an herb. In sum, he intends the disclosure to satisfy legal requirements, but he also intends to frame the disclosure coyly enough to enable the patient to find a "reason to believe."

The model is unlikely to serve either of Brown's aims. Would the disclosure satisfy informed consent doctrine? Whether viewed from the physician's or patient's perspective, the doctrine requires disclosure of all of the information a patient would wish to know. Wouldn't the patient choose to know that the substance is inert?

Moreover, even if Brown's model satisfies the mandates of the law, it surely will not serve the patient very well. If knowledge of a 50% chance of receiving a placebo in a controlled study significantly diminishes the placebo's effectiveness, knowledge that the substance does "not contain any drug" will blunt what otherwise might have been the placebo effect. There may be the occasional patient like the recipient of sham knee surgery who retains a clinical benefit after learning that he received a placebo.²¹² But, the overwhelming evidence indicates that a placebo's benefits dissipate after revelation of its use.²¹³

Brown might, however, argue that his model would satisfy Percival's goal of balancing the relative duties of veracity and beneficence. But, Percival would completely excuse veracity if deception would serve the patient. The placebo research reveals that absolute deception maximizes patient benefit. Moreover, Brown's coy disclosure does not serve veracity very well either.

Brown's model suffers from another shortcoming. It does not tie placebo use to placebo effectiveness. In effect, he proposes that the patient try the placebo. If it proves effective, then the physician will not prescribe conventional treatment. If the placebo does not prove effective, however, then the physician will turn to those established treatments.

The model contemplates placebo use when traditional treatments would be more effective. The net medical effect, then, may be detrimental to the patient, at least during the interval when

the patient experiments with the placebo. The failure to disclose that possibility hardly satisfies the obligations of informed consent. An adverse outcome hardly serves the patient's interests.

Percival would not have countenanced a placebo-caused injury to the patient:

The use of quack medicines should be discouraged ... as disgraceful to the profession, injurious to health, and often destructive of life. Patients, however, under lingering disorders, are sometimes obstinately bent on having recourse to such as they see advertised, or hear recommended, with a boldness and confidence, which no intelligent physician dares to adopt with respect to the means that he prescribes. In these cases, some indulgence seems to be required to a credulity that is insurmountable: And the patient should neither incur the displeasure of the physician, nor be entirely deserted by him. He may be apprized of the fallacy of his expectation, whilst assured, at the same time, that diligent attention should be paid to the process of the experiment he is so unadvisedly making on himself, and the consequent mischiefs, if any, obviated as timely as possible. Certain active preparations, the nature, composition, and effects of which are well known, ought not to be prescribed as quack medicines.²¹⁴

But if not injurious to the health, Percival would license sacrificing “that delicate sense of veracity.”²¹⁵ Yet, the physician should “guard sedulously against the injury” deception might cause. The right of the physician should be reserved to “real emergency,”²¹⁶ when the patient is “dangerously ill.”²¹⁷

I propose, then, to subject placebo use to two conditions. Placebos may only be used when they will clearly benefit the patient. Thus, the physician may deceive the patient only when the predictable effects of placebo exceed the predictable effects of established treatments. This will limit pure deception, as distinguished from disclosed placebo use in clinical trials, to only those conditions where medical research has verified that the placebo is more effective than the alternatives. As Frederick J. Evans has suggested: “A trial of placebo may be warranted where active medication is contraindicated, or where the active medication is too slow in working.”²¹⁸

Second, placebos may be prescribed without disclosure only when the patient is

“dangerously ill.” This allows guarding the right to information “sedulously.” The model will not dilute the relative duty of veracity beyond what is absolutely necessary to save a patient’s life.

The predictable effects of placebo may well exceed those of traditional medical treatment for common cold or other minor ailment. Indeed, where there is no established, effective treatment, any placebo effect would exceed the benefit of any other course of treatment. But, because the ailment is insignificant, the virtue in curing the patient does not rise above the virtue of veracity.

A Percivalian model, then, might license deception through placebo in the treatment of end stage HIV/AIDS or, as with Mr. Wright, cancer.²¹⁹ Where conventional treatments are unavailing, veracity’s virtue is diminished. “Under such a painful conflict of obligations, a wise and good man must be governed by those which are the most imperious.”²²⁰

B. Of Truth and the Efficacy of Treatment

Patient: Am I going to make it, Doc?
Doctor: Well, your case is quite serious, but there is hope. A new drug is available which has been very effective in treating some people who have the ailment that you have.
Patient: Oh, great. (But thinking, “there must be no hope. She’s giving me a placebo!”)

At least part of the placebo effect is due to a physician’s attitude and the physician’s relationship with his or her patient. For example, Arthur and Elaine Shapiro discovered that placebo effect can be increased if the physician states while administering the substance, “Your evaluation indicated that you should respond favorably to the test drug.”²²¹ The patient apparently transfers faith in the physician’s judgment to faith in the “medication.” As Herbert Spiegel put it, “The placebo effect can occur when conditions are optimal for hope, faith, trust, and love.”²²² Of

course, if faith in the physician falters, the placebo effect will too.

Doubt can do more than disrupt the impact of a single placebo application. “[T]here is hard data to support the notion that the emotional alliance between a doctor and patient is itself a therapeutic force.”²²³ For example, in 1987, British physician K.B. Thomas conducted an experiment on 200 patients who reported feeling sick but who exhibited no physical symptoms. He diagnosed one group with a specific ailment and predicted recovery in a few days. He truthfully informed the other group that he could not diagnose their malady and could not predict when they would recover. Sixty four percent of the first group reported improvement in two weeks. Thirty nine percent of the second group reported improvement.²²⁴

A study on postoperative pain yielded similar findings. Those who the night before surgery received a cordial explanation from the anesthetist about the pain to expect and the medication available required half the pain relief as a similar group who were merely told, “Don’t worry, everything is going to be all right.”²²⁵

As Galen observed more than a millennium ago: “He cures most successfully in whom the people have the most confidence.”²²⁶ More recently, medical anthropologist Daniel Moerman made the same point: “If a physician thinks this new drug is the greatest thing since sliced bread or if he’s really excited about a new theory, it always makes a difference. That’s one reason why the effectiveness of older drugs often wanes when a new one comes along.”²²⁷

Imagine, then, the impact of the use of placebos in accordance with the Hypothesis. Use under these circumstances -- when the predictable effect of placebo treatment exceeds that of traditional treatment -- will, by definition, improve outcomes. The benefit will continue so long as patients do not know of the placebo.

Can the placebo be concealed indefinitely? Surely not. The placebo has taken center stage in nearly all clinical drug trials. The results are published in professional and, often, lay journals and newspapers. So, patients surely will be aware of the existence of placebos.

But, will they be aware of just when, and in treatment of what ailments placebos will be used? Perhaps not. But, if placebo use is authorized only when conventional treatments are ineffective, then pharmaceutical companies would have incentive to market their wares as “more effective than placebos.” Only if they can prove so, will physicians be authorized to prescribe conventional treatment. The hypothesis, then, would lead to a competitive market between placebo and pharmaceutical or other treatment. As with all pharmaceuticals today, pharmaceutical companies surely would market their products directly to consumers, leading to a revelation of placebo treatment modalities.²²⁸

Use of placebos may only interject doubt into the therapeutic relationship with respect to maladies for which traditional medications have not proven effective. Of course, medical science does not stand still. Neither physicians, patients, nor pharmaceutical companies can ever know the point at which medications cease to work. If patients knew, then placebos could never work. Pharmaceutical companies conduct placebo control studies precisely to determine when their attempts have surpassed placebos in effectiveness.

The result under the hypothesis is two-fold. The circumstances under which a placebo may be used without disclosure will be very narrowly drawn. Moreover, patient suspicions will likely arise in a broader sphere of medical practice. Thus, not only will patient doubt tend to negate placebo use, but it will detrimentally impact practice where placebos are not typically used. Medicine will suffer a net loss in effectiveness.

That loss has a cultural dimension. Eve Sweetner has argued that “lying is a matter of more or less.”²²⁹ Cultural context informs both whether we view a statement as a lie and how we respond to a lie.²³⁰ In a “simplified world,” a lie is a false statement.²³¹ But, when placed in cultural context, the false statement, instead of being a lie, may, for example, be a “tall tale” or a “white lie.”²³²

The tall tale is measured for story value rather than truth value. “Grandpa’s *tall tales* of fifty foot snowfalls in his childhood are fun and harmless. Similar claims in a history book, however, would be *mistakes*, to say the least.”²³³

Culture sometimes sanctions “white lies” when “[t]ruth is seen as more harmful to the social situation than minor misinformation.”²³⁴ Or, in Percival’s language, “duty” sometimes transcends the obligation of “veracity” in the medical contexts.²³⁵ Thus, “[s]ome people would call it a white lie to tell a dying person whatever he or she needs to hear to die in peace.”²³⁶

But, other cultural markers may raise veracity’s value, especially in the context of patient and physician. “Doctors in particular derive much of their authority from large amounts of knowledge that is not otherwise accessible to patients.”²³⁷ Deception in this context constitutes an abuse of that authority, and can be destructive of the relationship that gave rise to the authority: “As [a] salient example[] of our view of lying as authority-abuse, let me cite the anger of patients lied to by doctors.”²³⁸

Anger may be the least destructive of the products of deception in medical practice. In 1903, Richard Cabot assessed the epidemiology and etiology of deceit in medical practice:

We think we can isolate a lie as we do a case of smallpox, and let its effect die with the occasion that brought it about. But is it not common experience that such customs are infectious and spread far beyond our intention and beyond our control?

They beget, as a rule, not any acute indignation among those who get wind of them (for “how,” they say, “could the doctor do otherwise”), but rather a quiet chronic incredulity which is stubborn.²³⁹

And, he offered a poignant illustration of a case of this affliction:

[Falsehood may assist a patient in avoiding] some suffering. But consider a minute. His wife has now acquired, if she did not have it already, a knowledge of the circumstances under which doctors think it merciful and useful to lie. She will be sick herself some day, and when the doctors tell her that she is not seriously ill, is she likely to believe them?²⁴⁰

So, too, with placebo use. Patients likely will acquire a “knowledge of the circumstances under which doctors think it” effective to use placebos. That knowledge likely will generate some anger. More importantly, “when the doctors tell” patients that a given medication will assist in recovery, are the patients “likely to believe them?”

IV. OF BENEFICENCE AND INFORMED CONSENT

Scholars typically have rooted the doctrine of informed consent in three principles.²⁴¹ Most prominently, writers have asserted that a respect for patient autonomy necessitates providing the patient with sufficient information to be able to make a free choice about the course of treatment.²⁴² Perhaps Jay Katz has expressed this principle most eloquently: Patients have the right “to make their own decisions without interference from others.”²⁴³ The paternalism that enables a physician to make a decision for the patient, “is one of self-determination’s contrary siblings.”²⁴⁴ Only by revealing all of the information relevant to “patients’ individual informational needs and patients’ concerns, doubt, and misconceptions about treatment”²⁴⁵ can physicians elude this sinister relative.

Others have “argued that rules of informed consent can be motivated less by a concern to promote autonomous choice than by a concern to promote justice.”²⁴⁶ For example, Charles Lidz

has been critical of the discourse in psychiatry regarding informed consent, especially as it pertains to the use of electroconvulsive therapy (ECT).²⁴⁷ Opponents of ECT have “sought to use informed consent as a technique to minimize the use of ECT by using premises of equity and fairness.” As Lidz characterizes this position, requiring disclosure is beneficial, apart from its relationship to autonomy, because it makes it less likely that patients will be subjected to injurious treatments.²⁴⁸ Escaping avoidable injury serves justice.

Finally, a few scholars have rooted the duty to inform in beneficence.²⁴⁹ This concept finds its origin in the Hippocratic command to the physician to “help, or at least do no harm.”²⁵⁰ The directive to “help” mandates that the primary objective of treatment be to benefit the patient. In the context of medical research, for example, this maxim of beneficence demands that the treatment benefit the patient, rather than the researcher or the general public.²⁵¹ Complete disclosure enables the patient to choose a course of treatment and, when the researcher’s interests may be inconsistent with the patient’s, facilitates resolving any conflict in the patient’s favor.

This proposition is particularly relevant to placebo research. The researcher may wish to administer a placebo as a control in a study of the efficacy of another treatment. Yet, the researcher knows that the placebo almost certainly will be the less effective of the two choices. Indeed, the research may be designed to measure just how much less effective placebo treatment is. Witness the controversy regarding placebo brain surgery.²⁵² Informing the patient of the placebo treatment may impair the research agenda. Concomitantly, however, disclosure will facilitate choices that benefit the individual patient.

The harm to patients is even clearer in therapeutic use of placebo. Deceiving the individual patient with a placebo when traditional treatments will be less effective serves that

patient. But the doubt injected into medicine impairs the treatment of future patients. In the turn-of-the-century words of Richard Cabot, “we have added to the lot of one person the suffering which we spare another.”²⁵³ The result is an argument for veracity premised on beneficence:

I am not saying that we ought to tell the truth in order to save our own souls or keep ourselves untainted. I am saying that a lie saves a person pain at the expense of greater future pain, and that if we saw as clearly the future harm as we see the present good, we could not help seeing that the balance is on the side of harm.²⁵⁴

Worthington Hooker made a similar point in an 1849 essay.²⁵⁵ The deception first injures the treated patient:

Everything you do [after deceiving the patient] is suspected, and a full and unshrinking trust is not accorded to you even when you deserve it If, for example, you wish to encourage a patient, and you tell him that though the bow of hope is dim to his eye, it is bright to your own: “Ah,” he will think, if he does not say, “how do I know but that it is as dim to him as it looks to me – he has deceived me once, and perhaps he does now.”²⁵⁶

But the deception also injures all patients who follow the originally deceived:

If it be adopted as a common rule, that the truth may be sacrificed in urgent cases, the very object of the deception will be defeated. For why is it that deception succeeds in any case? It is because the patient supposes that all who have intercourse with him deal with him truthfully.²⁵⁷

Even in the very unlikely event, lay and professional media and pharmaceutical companies notwithstanding, that subsequent patients do not discover the deception,²⁵⁸ the consequence for “professional duty” is unpalatable: “And yet if it be proper to deceive, then most clearly is it proper to proclaim it as an adopted principle of action. Else we are driven to the absurd proposition, that while it is right to practice deception, it is wrong to say to the world that it is right.”²⁵⁹

V. CONCLUSION: OF REVENGE

Beneficence was first the principle of Percival's ethics. His only objection to placebo was injury to patient. If "quack medicine" were proven not injurious to health, but beneficial to it when prescribed by a physician, however, Percival would surely countenance the prescription. After all, veracity is but "relative duty" which must be balanced against the "contending obligations" of "professional duty."²⁶⁰

Yet, this is a myopic vision of beneficence. The doubt created by common use of placebo would undermine both placebo and conventional therapies. The appropriate action to maximize treatment efficacy -- prohibiting the use of placebo without full disclosure -- produces informed consent. Percival viewed the duty to inform the patient as contrary to the physician's principal obligation to serve the patient's best interests. But, the obligation to disclose also serves the interest of beneficence. Honesty reduces the possibility of doubt, rendering treatment more effective. Patient autonomy may be a byproduct, and one that Percival did not value, but basing treatment decisions on the ultimate impact on the patient's health, would gratify Percival.

Percival only supported suspending a patient's right to being informed when "its beneficial nature being reversed, it would be deeply injurious" to the patient. Grounding informed consent in beneficence would reinstate Percival's demand that the right to information be subject to the information's predicted effect on the outcome of treatment.

Percival rejected Thomas Gisborne's suggestion that he qualify the mandate to convey "hope and comfort" by adding to his ethical precepts the phrase, "so far as truth and sincerity will admit."²⁶¹ Serving the patient's health is a "virtue of still higher calling."²⁶² When truth, ultimately, does serve health, not only can beneficence reign supreme, but Percival can rest assured that, at least in the context of placebo use, veracity and professional duty are equal

obligations.

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1 Don Mayhew, *Wright on Target from Off Center*, THE FRESNO BEE, May 8, 1998, at B5 (quoting comedian Steven Wright).

2 Bernie S. Siegel, LOVE, MEDICINE, & MIRACLES 33 (1986). Wright’s psychologist did not expect him to survive the weekend. *Id.* Siegel summarized the chart: “Tumors the size of oranges littered his neck, armpits, groin, chest, and abdomen. His spleen and liver were enormously enlarged. The thoracic lymph duct was swollen closed, and one to two quarts of milky liquid had to be drained from his chest each day. He had to have oxygen to breathe, and his only medicine now was a sedative to help him on his way.” *Id.*

3 *Id.*

4 *Id.* at 34.

5 *Id.* at 33-34. Klopfer added:

This phenomenon demanded an explanation, but not only that, it almost insisted that we open our minds to learn, rather than try to explain. So, the injections were given three times weekly as planned, much to the joy of the patient. ... Within 10 days he was able to be discharged from his “deathbed,” practically all signs of his disease having vanished in this short time. Incredible as it sounds, this “terminal” patient gasping his last breath through an oxygen mask was now not only breathing normally, and fully active, he took off in his own plane and flew to 12,000 feet with no discomfort.

Id. at 34.

6 *Id.*

7 *Id.*

8 *Id.*

9 *Id.* at 35.

10 *Id.*

11 Louisa Kasdon Sidell, *Doctors Bite Back! (Physicians' Candid Feelings About Practice, Alternative
Medicine and Patient Relations)*, 27 NATURAL HEALTH (July 17, 1998) (quoting Dr. Bernie Siegel).

12 *Id.*

13 Robert L. Park, *The Danger of Voodoo Science*, N.Y. TIMES, July 9, 1995, § 4, at 15.

14 The Food and Drug Administration's refusal to approve Laetrile for cancer treatment withstood a
lawsuit claiming a constitutional right to medical treatment of choice. *See generally* United States v.
Rugherford, 442 U.S. 544 (1979). Americans began going to Mexico in the 1950s to seek Laetrile
treatments. *See Why Laetrile Lived So Long*, N.Y. TIMES, Feb. 3, 1982, at A26. Despite substantial
evidence demonstrating Laetrile's ineffectiveness, 27 states eventually legalized its use. *See* Harold
M. Schmeck, Jr., *Final Report on U.S. Laetrile Study Says Drug Has No Value*, N.Y. TIMES, Jan. 28,
1982, at A14.

15 Sidell, *supra* note 11.

16 *Id.*

17 *Id.*

18 THE PLACEBO EFFECT: AN INTERDISCIPLINARY EXPLORATION 1 (Anne Harrington ed. 1997).

19 Sidell, *supra* note 11.

20 Thomas Percival, MEDICAL ETHICS: A CODE OF INSTITUTES AND PRECEPTS ADAPTED TO THE
PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS 1 (1803) (Special Edition, Edmund D.
Pellegrino, ed., 1985) (the quote is of editor Edmund D. Pellegrino).

21 *Id.*

22 *Id.* at 31-2.

23 Code of Ethics (1847) Art. I (4), *reprinted in* AMERICAN MEDICAL ETHICS REVOLUTION: HOW THE
AMA’S CODE OF ETHICS HAS TRANSFORMED PHYSICIANS’ RELATIONSHIPS TO PATIENTS,
PROFESSIONALS, AND SOCIETY 324, 325 (Robert B. Baker et al. eds. 1999).

24 *Id.*

25 *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. App. 1957).

26 For a critical discussion of the history of informed consent, see generally Jay Katz, *THE SILENT
WORLD OF DOCTOR AND PATIENT* (1984).

27 *See infra* notes 73-101 and accompanying text.

28 *See infra* notes 103-33 and accompanying text.

29 *See infra* notes 140-210 and accompanying text.

30 *See* Arthur K. Shapiro & Elaine Shapiro, *THE POWERFUL PLACEBO* 235 (1998) (“Our evaluations
indicated that you should respond favorably to the test drug” correlated with positive placebo effect.”).

31 *See infra* text accompanying notes 209-10.

32 David Spiegel, *Healing Words: Emotional Expression and Disease Outcome*, 281 J.A.M.A. 1328,
1329 (1999).

33 *See* PERCIVAL, *supra* note 20, at 165.

34 *See infra* notes 44-51 and accompanying text.

35 *See infra* notes 73-81 and accompanying text.

36 Tom L. Beauchamp & James F. Childress, *PRINCIPLES OF BIOMEDICAL ETHICS* 395 (4th ed. 1994).

37 *Id.*

38 *See id.*

39 Terrance McConnell, *MORAL ISSUES IN HEALTH CARE* 49 (2d ed. 1997) (reporting 88%).

40 *See infra* notes 73-101 and accompanying text.

41 MCCONNELL, *supra* note 39, at 49 (98%).

42 John D. Arras, *Principles and Particularities: The Roles of Cases in Bioethics*, 69 IND. L. REV. 983,
993-94 (1994).

43 *See infra* notes 103-33 and accompanying text.

44 Hippocrates works consist of “some seventy” manuscripts. I HIPPOCRATES vii (W.H.S. Jones
translation, 1957). “The Corpus is evidently the work of a large number of authors.” HIPPOCRATIC
WRITINGS 10 (G.E.R. Lloyd 1978).ed.,

45 A HISTORY AND THEORY OF INFORMED CONSENT 61 (Ruth R. Faden & Tom L. Beauchamp eds.
1986).

46 *Id.*

47 ETHICS IN MEDICINE 3 (Stanley Joel Reiser et al. eds. 1977).

48 A HISTORY AND THEORY OF INFORMED CONSENT *supra* note supply, at 61.

49 2 HIPPOCRATES, *Decorum* 297 (W. H.S. Jones, trans., 1967).

50 KATZ, *supra* note 26, at 6.

51 HIPPOCRATES, *supra* note 49.

52 L. MacKinney, *Medical Ethics and Etiquette in the Early Middle Ages: The Persistence of
Hippocratic Ideals*, 26 BULL. HISTORY OF MED. 1 (1952), *reprinted in* LEGACIES IN ETHICS AND
MEDICINE (C. Burns ed. 1977) *as quoted in* KATZ, *supra* note 26, at 8.

53 Katz, *supra* note 26, at 9.

54 PERCIVAL, *supra* note 20, at 7.

55 *Id.* Percival contended that the physicians and surgeons invited him to draft the code. Chauncey
Leake, who wrote the introduction to the book’s first edition, attributed the request to the hospital
trustees. *Id.* In either event, it is clear that “Percival occupied a position of unusual trust among his
colleagues.” *Id.* (quote is of the volume’s editor, Edmund D. Pellegrino).

56 *Id.* at 1 (quote is of the volume’s editor, Edmund D. Pellegrino).

57 *Id.* at 31-32.

58 Thomas Gisborne, ENQUIRY INTO THE DUTIES OF MEN IN THE HIGHER AND MIDDLE CLASSES OF SOCIETY IN GREAT BRITAIN RESULTING FROM THEIR RESPECTIVE STATIONS, PROFESSIONS, AND EMPLOYMENT (1794).

59 PERCIVAL, *supra* note 20, at 156-57.

60 *Id.* at 157.

61 *Id.* at 158 quoting GISBORNE, *supra* note 58, at Vol. II p. 148.

62 *Id.* at 160. Percival added, however, that “[t]he early Fathers of the Christian church ... were latitudinarians on this point.” *Id.* at 160-61.

63 *Id.* at 160.

64 *Id.* (emphasis in original).

65 *Id.*

66 *Id.* at 161. (quoting SPAVAN’S PUFENDORF, vol. II, at 9).

67 *Id.* at 162. (quoting Francis I. Hutcheson, HUTCHESON’S SYSTEM OF MORAL PHILOSOPHY 26). (preface by Dr. Leechman).

68 PERCIVAL, *supra* note 20, at 162. (quoting HUTCHESON *supra* note 67, at 33).

69 *Id.* at 166.

70 *Id.*

71 *See* PERCIVAL, *supra* note 20, at 165.

72 Lisbeth Haakonssen, MEDICINE AND MORALS IN THE ENLIGHTENMENT 170 (1997).

73 The AMA was then called the National Medical Convention. Robert Baker, THE CODIFICATION OF MEDICAL MORALITY 47 (1995).

74 *Id.*

75 A HISTORY AND THEORY OF INFORMED CONSENT *supra* note 45, at 69.

76 *Note to 1847 Convention, reprinted in* AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 23, at 315.

77 *See, e.g.,* BAKER, *supra* note 73, at 47-63. Baker contends that in an effort to make the Code acceptable to the AMA constituency, the drafters may have overstated Percival’s influence. *Id.*

78 Code of Ethics, *supra* note 23, at 324 (emphasis in original).

79 *Id.* at 325.

80 *See* KATZ, *supra* note 26, at 20 (Katz characterized the provision as “apparently troublesome”).

81 *Id.* at 22.

82 *Principles of Medical Ethics* (1957), as reproduced in AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 23, at 355.

83 *Id.* at 356.

84 *Id.* at 355.

85 KATZ, *supra* note 26, at 22.

86 *See Id.* at 23 (referring to malpractice law). For a discussion of informed consent case law, *see infra* notes 103-33 and accompanying text.

87 *Current Opinions of the Judicial Council* (1957), quoted in KATZ, *supra* note 26, at 22-3.

88 KATZ, *supra* note 26, at 23.

89 *Opinions of the AMA’s Judicial Council* (1957), as quoted in KATZ, *supra* note 26 at 22-3.

90 *See* Clark C. Havinghurst et al., HEALTH CARE LAW AND POLICY 527-541 (1998).

91 KATZ, *supra* note 26, at 23.

92 *Principles of Medical Ethics* (1980), as reproduced in AMERICAN MEDICAL ETHICS REVOLUTION *supra* note 23, at 358.

93 *Current Opinions of the Judicial Council* (1957), as quoted in KATZ, *supra* note 26, at 23.

94 *Id.*

95 *See id.*, opinion 8.08, at 134-35.

96 *Fundamental Elements of the Patient-Physician Relationship* Provision §1 (2000, available at <http://www.ama-assn.org/ama/pub/category/2510.html>).

97 *Id.*

98 *Id.* § 2.

99 *Id.* § 1.

100 *Id.*, preliminary paragraph.

101 See Edmund D. Pellegrino, *One Hundred Fifty Years Later: The Moral Status and Relevance of the AMA Code of Ethics*, in AMERICAN MEDICAL ETHICS REVOLUTION, *supra* note 23, at 107, 11-12.

102 Alan Donagan, THE THEORY OF MORALITY 89 (1977).

103 Although, in Jay Katz' view, the victory has not been complete. Despite the legal doctrine, "physicians have generally maintained that patients do not have the capacity to participate in decision making." KATZ, *supra* note 26, at 104.

104 95 Eng. Rep. 860, 2 Wils. K.B. 359 (1767).

105 2 Wils. K.B. at 360.

106 *Id.* at 362.

107 For a summary of early eighteenth century cases, see FADEN & BEAUCHAMP, *supra* note 45, at 23-119.

108 105 N.E. 92 (N.Y. 1914).

109 *Id.* at 93.

110 KATZ, *supra* note 26, at 50. For some criticism of Katz's characterization of these cases, see FADEN & BEAUCHAMP, note 45, at 124-25.

111 *Salgo*, 317 P.2d at 170.

112 See KATZ, *supra* note 26, at 65 (quote).

113 The language came from an *amicus* brief filed by the American College of Surgeons. KATZ, *supra* note 26, at 60-63.

114 *Salgo*, 317 P.2d at 181.

115 *Id.*

116 *Id.*

117 *Id.* (citing *Hunt v. Bradshaw*, 88 S.E.2d 762 (N.C. 1955)); *Simone v. Sabo*, 231 P.2d 19 (Cal. 1951); *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914).

118 FADEN & BEAUCHAMP, note 45, at 126.

119 KATZ, *supra* note 26, at 48.

120 FADEN & BEAUCHAMP, *supra* note 45, at 132.

121 At least one state continues to base informed consent actions in battery. See *id.* at 135.

122 See *id.* at 139. Legal scholarship also may have influenced the outcome. Allen McCoid had urged courts to embrace a negligent theory so that all malpractice-related claims would be premised on a

- single legal theory. *See* Allen McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 424-27 (1957), *as cited in* FADEN & BEAUCHAMP, *supra* note 45, at 127.
- 123 354 P.2d 670 (Kan. 1960).
- 124 FADEN & BEAUCHAMP, *supra* note 45, at 129.
- 125 354 P.2d at 675.
- 126 464 F.2d 772 (D.C. Cir. 1972).
- 127 *Id.* at 779.
- 128 *Id.* at 786.
- 129 *Id.* at 784.
- 130 *See* FADEN & BEAUCHAMP, *supra* note 45, at 139 (the legislation reflects “the political influence of physicians on state legislatures”).
- 131 For a critical discussion of the existence of a “crisis,” see generally W. John Thomas, *The Medical Malpractice “Crisis”: A Critical Examination of a Public Debate*, 65 TEMPLE L. REV. 459 (1992).
- 132 One study concluded that many of these statutes did little to change the common law rules in effect in the states. *See generally* Alan Meisel & Lisa D. Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980).
- 133 PERCIVAL, *supra* note 20, at 165.
- 134 *See generally* Alan Meisel, *The Exceptions to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WISC. L. REV. 413, 453-60. “A very small number of cases have acknowledged that a patient may waive his right to give an informed consent to treatment.” *Id.* at 453 (footnote omitted).
- 135 *Canterbury*, 464 F.2d at 789. *See generally* Meisel, *supra* note 134, at 460.
- 136 *Canterbury*, 464 F.2d at 789. For further discussion, *see generally* Meisel, *supra* note 134, at 460-70; Stephen Wear, INFORMED CONSENT: PATIENT AUTONOMY AND CLINICIAN BENEFICENCE WITHIN HEALTH CARE 22-23 (2d ed. 1998)
- 137 Alan Donagan, THE THEORY OF MORALITY 89 (1977).
- 138 Margaret Talbot, *The Placebo Prescription*, N.Y. TIMES MAG., Jan. 9, 2000, at 34, 36.
- 139 *Id.* at 35-36.
- 140 PLACEBO EFFECT, *supra* note 18, at 13.
- 141 *Talbot*, *supra* note 138, at 37.

- 142 *Id.*
- 143 *Id.*
- 144 See PLACEBO EFFECT, *supra* note 18, at 187 (quoting *Hooper's Medical Dictionary*).
- 145 *Id.*
- 146 Michel Foucault, *THE BIRTH OF THE CLINIC: AN ARCHEOLOGY OF MEDICAL PERCEPTION* (1963) (A.M. Sheridan Smith, trans., 1973).
- 147 PLACEBO EFFECT, *supra* note 18, at 187.
- 148 See PLACEBO EFFECT, *supra* note 18, at 15 (the authors suggest that the effectiveness of primitive medicine has been exaggerated by “[m]edical historians entranced by the presumed perspicacity of ancient healers”).
- 149 *Id.* at 13.
- 150 *Id.*
- 151 *Id.*
- 152 Paul Starr, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).
- 153 Richard C. Cabot, *The Use of Truth and Falsehood in Medicine: An Experimental Study*, 5 AM. MED. 344 (1903), *reprinted in* ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS (S. Reiser et al. eds. 1977).
- 154 Talbot, *supra* note 138, at 37.
- 155 Harry K. Beecher, *MEASUREMENT OF SUBJECTIVE RESPONSES: QUANTITATIVE EFFECT OF DRUGS* (1959). Beecher also published what is perhaps the seminal study of the ethics of placebo use in research. Henry K. Beecher, *Ethics & Clinical Research*, 274 NEW ENG. J. MED. 1354, 1356 (1966) (one group of military servicemen suffering from respiratory infections were given Penicillin while a control group were treated with a placebo).
- 156 PLACEBO EFFECT, *supra* note 18, at 3 (discussing Beecher’s work).
- 157 PLACEBO EFFECT, *supra* note 18, at 188 (citations omitted, emphasis in original).
- 158 W.H.R. Rivers, *THE INFLUENCE OF ALCOHOL AND OTHER DRUGS ON FATIGUE* (1908), *as cited in* PLACEBO EFFECT, *supra* note 18, at 20.
- 159 H.L. Hollingsworth, *The Influence of Caffeine on Mental and Motor Efficiency*, 22 ARCH. PSYCHOL. 1-166 (1912), *as cited in* PLACEBO EFFECT, *supra* note 18, at 20.
- 160 Ella M. Hediger & Harry Gold, *U.S.P. Ether from Large Drums and Ether from Small Cans Labeled “For Anesthesia,”* 104 J.A.M.A. 2244, 2245 (1935).

- 161 Harry Gold et al., *The Xanthines (Theobromine and Aminophylline) in the Treatment of Cardiac Pain*, 108 J.A.M.A. 2173, 2173 (1937).
- 162 PLACEBO EFFECT, *supra* note 18, at 20.
- 163 *Id.* at 20-21.
- 164 *Id.* at 187-88.
- 165 Frederick J. Evans, *Expectancy, Therapeutic Instructions, and the Placebo Response*, in PLACEBO: THEORY, RESEARCH AND MECHANISMS 215, 219 (L. White et al. eds. 1985) (Evans was reporting on six double-blind studies).
- 166 *Id.* at 223.
- 167 *Id.*
- 168 Jon D. Levine & Newton C. Gordon, *Influence of the Method of Drug Administration on Analgesic Response*, 312 NATURE 755 (1984).
- 169 PLACEBO EFFECT, *supra* note 18, at 100.
- 170 Walter A. Brown et al. *Clinical Features of Depressed People Who Do and Do Not Improve with Placebo*, 41 PSYCHIATRY RESEARCH 203, 203 (1992). “The response to placebo among depressed patients appears to be bimodal; most depressed patients either recover completely with placebo or show little improvement.” *Id.* (footnote omitted).
- 171 THE POWERFUL PLACEBO, *supra* note 30, at 79.
- 172 Herbert Benson & David P. McCallie, Jr., *Angina Pectoris and the Placebo Effect*, 300 NEW ENG. J. MED. 1424, 1424 (1979).
- 173 *Id.*
- 174 *Id.*
- 175 Benson & McCallie, Jr., *supra* note 172, at 1428.
- 176 Benson & McCallie, Jr., at 1425.
- 177 “Ligation” is “the surgical process of tying up a blood vessel.” WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY (UNABRIDGED) 1307 (1993).
- 178 Benson & McCallie, Jr., *supra* note 172, at 1426, (citing Leonard A. Cobb et al., *An Evaluation of Internal-Mammary Ligation by a Double-Blind Technique*, 260 NEW ENG. J. MED. 1115 (1959) & E.G. Dimond, *Evaluation of Internal Mammary Ligation and Sham Operation for Angina Pectoris*, 18 CIRCULATION 712 (1958)).
- 179 Talbot, *supra* note 138, at 34. Of the five surgical patients, two received scraping and rinsing of the knee joint while three received only rinsing. *Id.*

180 *Id.* at 36.

181 For a general description of the study, see Laura Johannes, *First Cut: Sham Surgery Is Used to Test Effectiveness of Novel Operations*, WALL ST. J., Dec. 11, 1998, at A1. For a detailed discussion, see Thomas B. Freeman et al., *Use of Placebo Surgery in Controlled Trials of a Cellular-Based Therapy for Parkinson's Disease*, 341 NEW ENG. J. MED. 988 (1999). *See also* Neetha Shetty et al., *The Placebo Response in Parkinson's Disease*, 22 CLIN. NEUROPHARM. 207, 207 (1999) (concluding that, “Although there is clearly a placebo response in PD patients, our review suggests that the variation in placebo response does not correlate with demographic factors such as age, gender, religion, level of education, or duration of PD.”).

182 Johannes, *supra* note 181. The committee rejected Yale University’s proposal because it did not offer placebo surgeries. *Id.*

183 *Id.*

184 *Id.*

185 Talbot, *supra* note 138, at 35 (quoting Dr. Bruce Mosley reporting on a conversation with Nelda Wray, a physician and research director at the Houston Veteran Administration’s hospital).

186 From the Tim Hardin song of the same title. *See Music Must-Know Info*, TORONTO SUN, Dec. 29, 1999, at 18.

187 PLACEBO EFFECT, *supra* note 18, at 188 (citations omitted, emphasis in original).

188 Talbot, *supra* note 138, at 38.

189 *See* PLACEBO EFFECT, *supra* note 18, at 4.

190 *Id.*

191 *Id.*

192 Jon D. Levine et al., *The Mechanism of Placebo Analgesia*, 23 LANCET 654, 654 (1978) (“These data are consistent with the hypothesis that endorphin release mediates placebo analgesia for dental postoperative pain.”). A subsequent study confirmed these findings. *See* Levine & Gordon, *supra* note 168.

193 Jonathan J Lipman et al., *Peak B Endorphin Concentration in Cerebrospinal Fluid: Reduced Chronic Pain in Patients and Increased During the Placebo Response*, 102 PSYCHOPHARM. 112, 112 (1990).

194 F. Benedetti et al., *Somatotopic Activation of Opioid Systems by Target-Directed Expectations of Analgesia*, 19 J. NEUROSCIENCE 3639, 3639 (1999).

195 Talbot, *supra* note 138, at 37-38.

196 Robert Ader & Nicholas Cohen, *Behaviorally Conditioned Immunosuppression*, 37 PSYCHOMATIC MED. 333, 335-39 (1975).

- 197 Nicholas J. Voudoris et al., *The Role of Conditioning and Verbal Expectancy in the Placebo Response*, 43 PAIN 121, 126-27 (1990).
- 198 Charles G. Moertel et al., *Who Responds to Sugar Pills?*, 51 MAYO CLINIC PROC. 96, 98-100 (1976).
- 199 Stewart Wolf, *Effects of Suggestion and Conditioning on the Actions of Chemical Agents in Human Subjects*, 29 J. CLINICAL INVESTI. 100, 108-09 (1950).
- 200 Spiegel, *supra* note 32, at 1329.
- 201 *Id.*
- 202 Joshua M. Smyth et al., *Effects of Writing about Stressful Experiences on Symptom Reduction in Patients with Asthma or Rheumatoid Arthritis*, 281 J.A.M.A. 1304 (1999).
- 203 *Id.* at 1305.
- 204 *Id.* at 1308.
- 205 *Id.* at 1309.
- 206 Robert D. Hershey, Jr., *Rise in Death Rate After New Year Is Tied to the Will to See 2000*, N.Y. TIMES, Jan. 15, 2000, at A1 (“1,791 people who saw out 1999 died in the first week of 2000, 50.8 percent more than the 1,187 who died in the same period in 1999, and 46 percent more than the 1,226 people who died in the last week of 1999, according to the New York City Department of Health. In 1998 there were 1,305 deaths in the first week of the year.”).
- 207 *Id.* (quoting Richard M. Suzman).
- 208 PLACEBO EFFECT, *supra* note 18, at 248 (quoting Stephen Kosslyn).
- 209 *Id.* at 22.
- 210 See Talbot, *supra* note 138, at 58 (medical anthropologist explaining why new drugs are most effective).
- 211 *Id.* at 38.
- 212 See *supra* note 180 and accompanying text.
- 213 PLACEBO EFFECT, *supra* note 18, at 29-31.
- 214 PERCIVAL, *supra* note 20, at 44-45.
- 215 *Id.* at 166.
- 216 *Id.*
- 217 *Id.* at 167.

218 Evans, *supra* note 165, at 225.

219 *See supra* notes 1-10 and accompanying text.

220 PERCIVAL, *supra* note 20, at 166.

221 PLACEBO EFFECT, *supra* note 18, at 31.

222 Talbot, *supra* note 138, at 60.

223 *Id.* at 44.

224 *Id.* at 58.

225 *Id.*

226 *Id.*

227 *Id.*

228 For a discussion of direct-to-consumer marketing of pharmaceuticals, see generally W. John Thomas, *Direct-to-Consumer Pharmaceutical Advertising: Catalyst for a Change in the Therapeutic Model in Psychotherapy*, 31 CONN. L. REV. 209 (1999).

229 Eve E. Sweetner, *The Definition of a Lie: An Examination of the Folk Models Underlying a Semantic Prototype*, in Dorothy Holland & Naomi Quinn, CULTURAL MODELS IN LANGUAGE AND THOUGHT 43 (1987).

230 *See id.* at 62-3.

231 *Id.* at 50.

232 *Id.* at 52.

233 *Id.* (emphasis in original).

234 *Id.* at 54.

235 PERCIVAL, *supra* note 20, at 166.

236 Sweetner, *supra* note 229, at 54.

237 *Id.* at 59.

238 *Id.*

239 Cabot, *supra* note 153, at 216.

240 *Id.*

241 FADEN & BEAUCHAMP, *supra* note 45, at 7-16.
242 *Id.* at 7-8.
243 KATZ, *supra* note 26, at 105.
244 *Id.* at 110.
245 *Id.* at 78.
246 FADEN & BEAUCHAMP, *supra* note 45, at 15.
247 Charles W. Lidz et al., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY ? (1984).
248 *Id.*
249 FADEN & BEAUCHAMP, *supra* note 45, at 9-14.
250 *Id.* at 10. The authors note that although the maxim is most frequently expressed as, “above all, do no harm,” [r]ecent scholarship has shown that in the Hippocratic writings the more precise formulation of the primary moral injunction” is as stated in the text. *Id.* (footnotes omitted).
251 *See id.* at 14. For a more complex discussion of the countervailing concerns in determining how best to benefit the patient, see *id.* at 11-14. Simply put, some physicians contend that it is sometimes most beneficial to the patient to override the patient’s choices. *Id.* at 13.
252 *See supra* notes 181-84 and accompanying text.
253 Cabot, *supra* note 153, at 216.
254 *Id.*
255 Worthington Hooker, *Truth in Our Intercourse with the Sick*, in ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS 206 (1977).
256 *Id.* at 207-08.
257 *Id.* at 210.
258 *See supra* note 228 and accompanying text.
259 Hooker, *supra* note 255, at 210.
260 PERCIVAL, *supra* note 20, at 166.
261 *Id.* at 156-57.
262 *Id.* at 160.