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If we are at least aware of the emerging literature on PNEs and can accept that “people’s preferences and values are to some extent indeterminate, unstable, and context sensitive” (Alfano 2015, 11), then it is much easier to see that framing and shaping advice is not deceptive when undertaken with patient consent. Indeed it is difficult to imagine how a patient would find objectionable a preamble to advice giving that indicated that giving them information in a certain way could increase their benefits and reduce their potential for harms from a form of therapy. Indeed, it would be ethically objectionable not to do so.

As Alfano and others have noted, whether physicians “like” it or not, PNEs effects are undoubtedly evoked by and operate within physician–patient encounters, and if we are committed to using therapies supported by the best currently available evidence, then we must destigmatize the PE and harness it to optimize patient outcomes. ■

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Authorized Concealment and Authorized Deception: Well-Intended Secrets Are Likely to Induce Nocebo Effects

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Informed consent, as Alfano (2015) recognizes, has been routinely idealized within philosophical debate: Philosophers typically present a psychologically sanitized formulation of the temporal sequence of events (physician disclosure followed by patient deliberation, and treatment acceptance or refusal). Within health care ethics there is still a tendency to ignore the work of cognitive scientists, such as Kahneman and Tversky, and Gigerenzer, and Alfano bucks this trend by putting the psychology of decision-making at centre stage. His contribution has the potential to revitalize the moral debate on clinical placebos and nocebos.

A key theme of the article is how best to solve the problem of the nocebo effect in informed consent. However, in

light of existing scientific research into the psychology of secrecy, I advise that Alfano’s solutions to this problem (like those of his predecessors) require a rethink. I present some suggestions for evidence-led improvements on these proposals—whether they are in keeping with his libertarian paternalism (or whether that is an oxymoron) I will leave for others to decide.

Alfano emphasizes that how disclosures are framed, as well as the content of those disclosures, has the potential to influence not only the occurrence of symptoms but also the patient’s decision-making process (cf. Colloca and Miller 2011; Miller and Colloca 2011). A major goal of the article is to enquire how physicians might ethically navigate the Scylla and Charybdis of nonmaleficence and

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respect for autonomy. When it comes to placebo effects the content of disclosure appears to be (relatively) straightforward: Alfano proposes that physicians should mention benefits to patients “if the probability of a benefit occurring given that it’s mentioned is greater than the probability of the same benefit occurring given that it’s not mentioned” (8). When it comes to a potential harm, however, he argues that “*physicians should think twice before mentioning it*” (8, emphasis added). The problem is: How might physicians avoid triggering adverse symptoms that directly derive from truthful disclosures? In short, how can we ethically avert nocebo effects?

Alfano acknowledges that his proposed solution to avoiding nonmaleficent nocebo effects builds on strategies proffered by “Miller, Kaptchuk, Colloca, and others” (8); to wit, that physicians should deploy authorized concealment or deception in some contexts. The idea behind authorized concealment is to seek the permission of the patient not to disclose possible side effects to avoid the potential for negative outcomes. He contends that authorized concealment is a risky strategy: The patient may become more anxious (perhaps overestimating the size and probability of the side effects actually occurring), or (alternatively) may underestimate the importance of any experienced symptoms and dismiss them as insignificant *qua* side effects. In a bid to override these problems he presents a solution: “The physician could provide the patient with a ‘bad fortune cookie’—essentially, just a list of potential side effects that she concealed, in a sealed envelope” (8) Alfano submits that there is the potential for patients “always (or never)” to open their envelopes but argues these are empirical questions about which we currently lack an answer. In a similar vein, when it comes to authorized deception—wherein doctors seek permission to mislead the patient about aspects of the treatment—Alfano tenders that, here again, doctors might deploy “bad fortune cookies,” a stratagem that might also be supplemented by an “agony aunt” who “would be told the truth about the patient’s prospects, asked to keep an eye on him, but instructed not to reveal the deception unless it seemed necessary” (9). On the face of it these seem highly reasonable ideas. However, there exists sufficient empirical evidence to infer that both of these proposals are liable to aggravate or induce nocebo responses rather than prevent them occurring.

A wealth of evidence from research into the psychology of confidentiality shows that the ascription of secrecy to information is no guard against its transmission—in fact, quite the opposite: When it comes to keeping secrets, “confidentiality may well be the exception rather than the rule” (Christophe and Rime 1997). Research shows that even secrets that are judged of low interest are likely to be transmitted to others; in such cases, studies show that disclosures to second and third parties occur two-thirds of the time, and this increases to nearly 80% when the secret disclosures are judged to be of intense emotional relevance to the listener (Christophe and Rime 1997). We also know that people are chiefly interested in secrets and

information that have the potential to affect their lives, including (but not restricted to) news about their health (Barkow 1992). Finally, studies show that the very act of flagging significant information and then concealing it increases the value of the hidden facts; in other words, it intensifies listeners’ desire to uncover such knowledge (Christophe and Rime 1997; Kelly 1999; Yovetich and Drigotas 1999). This is why psychologists counsel (*contra* conventional wisdom) that telling someone a secret and then issuing a prior restraint phrase (such as telling them not to tell anyone else) acts directly to undermine the request (Petronio and Bantz 1991; Kelly 1999).

How does this research undermine the proposal that authorized concealment or deception (either in the form of bad fortune cookies or agony aunts) is liable to be effective? Informed consent in both strategies appears to make a theatrical event out of hidden information, thereby elevating its premium and the desire to unmask it. In the case of bad fortune cookies (which rely on the patient to collude—albeit in ignorance—with a secret about herself) the patient need only (privately) tear open the envelope in order to satisfy her curiosity. Notice that the information is already of high intrinsic interest since it includes potential facts about her future personal health. In the agony aunt scenario (even if it is routinely possible to set up this rather elaborate health care relationship), research predicts that the agony aunt can be expected to disclose these facts to others (Christophe and Rime 1997). Therefore, even if the patient does not obtain this information via his agony aunt (or via their second- and third-party confidantes), his demands and piqued interest—which (as we have noted) will likely be a by-product of the intricate social scenario—might easily be supplied by a Google search and medication fact check. Indeed, even if medical apps were designed in order to substitute for (real, offline) agony aunts, this risk would still prevail.

In summary, there are credible empirical grounds for the view that Alfano’s proposals (just like those of his predecessors) may incite patients to find out more about side effects and, as a result, significantly increase their chances of experiencing nocebo responses (thereby igniting the very problem we hope to extinguish).

I tentatively suggest another direction, one that builds on the work of cognitive scientists such as Gigerenzer, whom Alfano mentions within his article. Gigerenzer argues that while humans are not intuitive statisticians, how statistics are presented to us can influence our decision making (e.g., one may frame a probability negatively as a 10% chance of dying, or positively as a 90% chance of surviving—while logically equivalent, each may induce different decisions) (Gigerenzer 2007, 99). I suggest that when it comes to nocebo effects the doctor might package the disclosure in the following way:

If you take this drug you have a 70 percent chance of feeling better. We can talk about the low risk of side effects if you like but research shows that if we don’t dwell on these things, you will have an 80 percent chance of avoiding any unnecessary

and unpleasant symptoms. Therefore I'd like to recommend this treatment because of its success rate, and if at any time you need to see me again just make appointment.

Such a strategy may help to positively frame the treatment and avert elaborate and theatrical attention to side effects while also mentioning them—in passing. It goes further than previous, more tentative suggestions that framing is relevant in the context of the nocebo effect (Miller and Colloca 2011; Colloca and Miller 2011). It is arguably a solution in keeping with Alfano's libertarian paternalism and consistent with my own previous arguments that health professionals have a duty not only to provide adequate information to patients but also to be "well-informed" about the long- and short-term health behavior (and health implications) of any such disclosures (Bleasle 2014). ■

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Clinical Placebo Can Be Defined Positively: Implications for Informed Consent

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THE CHALLENGE OF CLINICAL PLACEBO

The conceptual and ethical challenges regarding clinical placebo are interwoven with each other, so that one's definition of clinical placebo influences the moral reasoning with regard to its use in clinical practice. Thus, for example, if the placebo is perceived as "an inert substance," prescribing it in clinical practice would tend to be considered inappropriate. If, however, the placebo were considered an effective therapeutic tool, its use in clinical practice would more likely be legitimized. Since we share with Alfano (2015) several tenets, such as discontent with negatively oriented definitions of placebo, awareness of the

psychological underpinnings of the placebo effect, and resistance to the hegemony of autonomy in the therapeutic realm, we basically concur with the "pro-placebo" policy he advocates.

Nevertheless, the suggestion to reduce the discussion of the clinical placebo to the psychological mechanisms that underlie its effect seems to us to be conceptually mistaken. Based on the same principles that have been mentioned by Alfano, we have suggested a positive definition of clinical placebo (Gold and Lichtenberg 2014). Our definition entails a few conceptual and practical implications that may shed light on the controversy around the use of placebo in clinical practice.

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