PLACEBO: DECEPTION AND THE NOTION OF AUTONOMY

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Abstract: *In this short essay I intent to discuss the moral standing of autonomy in the field of Medical Ethics and the way it affects individual decision making as well as health care policies. To this purpose I will employ a real life scenario, namely administering placebo medication to a patient without letting him know, by means of which I will challenge not only the effectiveness and the feasibility of autonomy in the Kantian sense, but also its desirability. I will argue that the Kantian notion of autonomy when it comes to Medical Ethics is in some cases self-defeating and, therefore, confusing and misleading. I will conclude with the view that, at least as Medical Ethics is concerned, we should rethink and, maybe, revise the meaning we usually assign to autonomy, so as to take into account the particular nature of the doctor-patient relationship.*

Keywords: *autonomy, disclosure, Kantian ethics, Medical Ethics, placebo, deception, doctor-patient relationship.*

Introduction

Major philosophical traditions do not just perish; they always leave something behind and continue to cast their shadow on the way we think, perceive the world, make our decisions and interact with other people. This is *a fortiori* the case with major traditions in ethics, since ethical theories are by definition purposed to have as much impact as they can afford on everyday life. When it comes to Medical Ethics, this couldn't be truer than with regard to the Kantian tradition, still the most influential ethical system in western medicine, since its core element and cornerstone, the principle of autonomy of the moral agent, has become the most central value in health-care ethics. In this short essay I intent to discuss the moral standing of autonomy in the field of Medical Ethics and the way it affects individual decision making as well as health care policies. To this purpose I will employ a real life scenario, namely administering placebo medication to a patient without letting him know, by means of which I will challenge not only the effectiveness and the feasibility of autonomy in the Kantian sense, but also its desirability. I will argue that the Kantian notion of autonomy when it comes to Medical Ethics is in some cases self-defeating and, therefore, confusing and misleading. I will conclude with the view that, at least as Medical Ethics is concerned, we should rethink and, maybe, revise the way we understand autonomy, so as to take into account the particular nature of the doctor-patient relationship.

The notion of autonomy

Autonomy in general, everybody can tell, is not an easy goal to pursue; by this I mean not only that it is hard to achieve, but also that an autonomous life is not a convenient fashion to live after. In medical practice, in particular, most of the times autonomy comes at the expense of effectiveness and utility; nevertheless, no matter what each time the stake is, almost all codes of medical ethics or professional conduct clearly mandate that autonomy should be sought, preserved and safeguarded by all means. This is due to the fact that on the one hand the autonomy of the patient is usually quite vulnerable, and on the other because it is precious – in the words of Kant the property of autonomy is the ground of dignity of the human and of every rational nature, as well as the sole principle of morality. To cast more light on this view I will provide a brief outline of the way Kant perceives autonomy.

According to Kant,

> "The will is a species of causality of living beings, insofar as they are rational, and freedom would be that quality of this causality by which it can be effective independently of alien causes determining it; just as natural necessity is the quality of the causality of all beings lacking reason, of being determined to activity through the influence of alien causes."[1]

In that sense freedom and free will appear to be either interwoven, bound up, or even identical to autonomy[2], the latter defined by Kant as "the property of the will through which it is a law to itself."[3] But why is autonomy the ground of dignity? In order to fully grasp this we have to move back to Seneca and his pivotal

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[1] Immanuel Kant, *The Groundwork for the Metaphysics of Morals*, edited and translated by Allen Wood (New Haven and London: Yale University Press, 2002), 63 [Ak 4:446].

[2] Ibid., 63 [Ak 4:447]: "[…] what else, then, could the freedom of the will be, except autonomy, i.e., the quality of the will of being a law to itself? […] thus a free will and a will under moral laws are the same". Cf. 66, [Ak 4:449]: "It therefore appears as if in the idea of freedom we really only presupposed the moral law, namely the principle of the autonomy of the will itself, and could not prove its reality and objective necessity for itself"; also 66 [Ak 4:450]: "One must freely admit it that a kind of circle shows itself here, from which, it seems, there is no way out. In the order of efficient causes we assume ourselves to be free in order to think of ourselves as under moral laws in the order of ends, and then afterward we think of ourselves as subject to these laws because we have attributed freedom of the will to ourselves, for freedom and the will giving its own laws are both autonomy,hence reciprocal concepts, of which, however, just for this reason, one cannot be used to define the other and provide the ground for it, but at most only with a logical intent to bring various apparent representations of the same object to a single concept (as different fractions with the same value are brought to the lowest common denominator)"; finally 69 [Ak 4:452]: "Now with the idea of freedom the concept of autonomy is inseparably bound up".

[3] Ibid.,58 [Ak 4:440].

distinction between *pretium* and *dignitas*. "Bodily goods are", Seneca claims, "good for the body; but they are not absolutely good. There will indeed be some value in them; but they will possess no genuine merit, for they will differ greatly; some will be less, others greater."[4] Tagging along with Seneca Kant claims that,

> "In the realm of ends everything has either a price or a dignity. What has a price is such that something else can also be put in its place as its equivalent; by contrast, that which is elevated above all price, and admits of no equivalent, has dignity. That which refers to universal human inclinations and needs has a market price; that which, even without presupposing any need, is in accord with a certain taste, i.e., a satisfaction in the mere purposeless play of the powers of our mind, an affective price; but that which constitutes the condition under which alone something can be an end in itself does not have merely a relative worth, i.e., a price, but rather an inner worth, i.e., dignity. Now morality is the condition under which alone a rational being can be an end in itself, because only through morality is it possible to be a legislative member in the realm of ends. Thus morality and humanity, insofar as it is capable of morality, is that alone which has dignity."[5]

And since being capable of morality requires free agency, to wit agency "as a special kind of causality, namely a causality that acts under normative principles, hence a capacity to choose between alternatives according to one's judgment about which alternative is permitted or required by a norm"[6], autonomy is "the ground of the dignity of the human and of every rational nature."[7] To make a long story short: the property of rationality extracts mankind from the realm of natural heteronomy and facilitates free agency, in other words autonomy. Autonomy is a *conditio sine qua non* for morality[8], and morality in turn is thus the ground of dignity for human beings.[9]

Autonomy and real-life scenarios

Let's move to the way Kant's account of autonomy affects real life issues

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[4] Seneca, *Ad Lucilium epistulae morales*, translated by Richard Gummere (London: William Hainemann, 1970), vol. II, LXXI 33-34: "Corporumautem bona corporibusquidem bona sunt, sed in totum non sunt bona. His pretium quidem erit aliquod, ceterum dignitas non erit; magnis inter se intervalis distabunt; alia minora, alia maiora erunt". "Genuine merit" (dignitas) is often also translated as "true worth": see Seneca, *Letters On Ethics to Lucilius*, translated with intro and commentary by Margret Graver and A. A. Long (University of Chicago Press 2015), p. 221.

[5] Kant, *The Groundwork*, 52-53 [Ak 4:434-5].

[6] Allen W. Wood, "What Is Kantian Ethics?", in Immanuel Kant, *The Groundwork for the Metaphysics of Morals*, edited and translated by Allen Wood,157-181 (New Haven and London: Yale University Press, 2002), 175.

[7] Kant, *The Groundwork*, 54 [Ak 4:436].

[8] Ibid.

[9] Ibid.

now. Pursuant to the view I just outlined, almost all codes of medical ethics and professional conduct incorporate strict provisions forbidding the doctor or the medical staff not to tell the truth or not to disclose all crucial and relevant information to the patient.[10] The reason for this is that if the doctor was allowed the freedom to do otherwise, the autonomy of the patient would be severely compromised, and he – the patient – instead of being treated "always at the same time as an end in itself"[11], would be reduced to just a mere means to an end; and, as shown before, compromising one's autonomy is unacceptable regardless of the stake: should it be the convenience of the doctor or the medical staff, or the effective allocation of resources, or even the patient's own best interests, all these have to be cast aside if they are to come through lying, concealing the truth or withholding information, since all such options would be violating the patient's autonomy. To rephrase Ronald Dworkin's famous aphorism, autonomy tramps utility[12], and this admits of no circumstantial exceptions.

Doesn't it? Well, in a Kantian universe this would definitely be the case. But our universe, the only one we will ever know, is not such stuff as Kantian principles or imperatives are made on – at least *not only* such stuff. In real life autonomy may have to be sometimes balanced with utility, at least inasmuch as the patient himself looks up to the doctor not as a champion of autonomy, but just as a healer or a life giver.

To make this clear, let us consider a case in which a patient could have either his autonomy respected and preserved, or his health condition successfully treated. What should prevail then? Let the situation be like this: John is 40 years old and he is married to Jane 5 years already. John two years ago had to go through some extremely difficult situations that emerged all together at the same time, exactly as difficult situations usually tend to do in the life of humans: first he had to deal with his mother passing away, to whom he was strongly attached; a few months later he lost his job, so there was only Jane's salary for both of them to live on. The combination of these two personal calamities drove him into a plight which probably triggered some inherent – up to then inert – genetic tendency, and soon John was diagnosed with major depression disorder. This, of course, became a huge impediment to his personal as well as social life, so John had to ask for an expert's help. Luckily enough in John's case MDD could be successfully controlled, but only by means of a carefully designed and complex therapy. John's doctor, however, is rather reluctant to proceed with such a therapy. He has been made aware of John's and Jane's fervent wish to acquire offspring, and he knows that they both now are at their peak years of fertility. John's therapy, highly effective as it may

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[10] T. Goffin, Herman Nys, Pascal Borry and Kris Dietrickx, "Patient Rights in the EU - Greece", *European Ethical-Legal Papers* 6, Leuven, 2007.

[11] Kant, *The Groundwork*, 55 [Ak 4:437].

[12] Ronald Dworkin, *Taking Rights Seriously* (Cambridge, Massachusetts: Harvard University Press, 1978), 190-192.

be, as a side effect largely reduces – if not totally eliminates – sexual desire. Since the therapy is going to last for as long as John lives, John and his wife are unlikely to ever have any children without resorting to assisted reproduction services – but it doesn't seem likely they will ever be able to afford such services given their poor financial condition. This puzzle would be impossible, but actually there seems to be a way out: placebo[13] treatments have been tested to be almost as effective in the case of major depression disorder as conventional ones. As a matter of fact clinical trials show that depression is a highly placebo-responsive condition: mean placebo response rises up to 46%, while mean standard medication response is as high as 59%[14]; this 13% superiority gap on behalf of conventional medication may easily be compensated by the total absence of side effects when placebo medication is administered. In short, if the doctor decides to administer sugar pills to John, John would have almost equally good chances to maintain his condition under control and he will definitely acquire offspring. There is only a minor setback: John shouldn't be aware of the fact that he is receiving sugar pills; he should have to be deceived into believing that he still receives conventional medication, otherwise responsive rates would fall at as low as 18%. But deciding for a placebo prescription is not even an option for John's doctor, since if the doctor would decide to withhold the truth he would compromise John's autonomy and, hence, he would severely damage his morality and dignity, not to mention that this would be against the law and would leave the doctor vulnerable to law suits. The fact that he would be doing so in order only to benefit John would be morally irrelevant, since, as I previously said, *autonomy trumps* utility in any case and irrespective of any anticipated benefit.

Autonomy as a safety-valve: A utilitarian account

As I previously implied, utility issues should be considered irrelevant in the case of John and John's doctor. Contemporary Bioethics seems to assume some kind of threshold after which all concerns regarding the utility of any choice of ours become totally transparent, although just before it they are as tangible as it

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[13] Placebo is "a preparation containing no medicine (or no medicine related to the complaint) and administered to cause the patient to believe that he is receiving treatment." Pedro Luis Dago and Frederic M. Quitkin, "Role of the Placebo in Depressive Disorders", *CNS Drugs* 4 (1995): 335-340; according to Shapiro the term placebo applies to "any therapy or component of therapy that is deliberately used for its nonspecific, psychological, or psychophysiological effects, or that is used for its presumed specific effect, but is without specific activity for the condition being treated." See Arthur K. Shapiro, "A Historic and Heuristic Definition of the Placebo", *Psychiatry* 27 (1964): 52-58. Brody defines placebo as "a form of medical therapy, or an intervention designed to simulate medical therapy, that at the time of use is believed not to be a specific therapy for the condition for which it is offered and that is used either for its psychological effect or to eliminate observer bias in an experimental setting; [or is] a form of medical therapy now believed to be inefficacious, though believed efficacious at the time." See Howard Brody, "Placebo Effect", in Leonard White, Bernard Tursky and Gary E. Schwartz (eds.), *Placebo: Theory Research and Mechanisms*, 39–49 (New York Guilford Press: New York, 1985).

[14] Jeffrey A. Bridge, Boris Birmaher, Satish Iyengar, Rémy P. Barbe & David A. Brent, "Placebo Response in Randomized Controlled Trials of Antidepressants for Pediatric Major Depressive Disorder", *American Journal of Psychiatry* 166 (2009): 42-49. See also Bret R. Rutherford and Steven P. Roose, "A Model of Placebo Response in Antidepressant Clinical Trials", *American Journal of Psychiatry* 170 (2013): 723-733.

gets; the threshold, of course, is the potentially effect on autonomy of the moral agent, a capacity that should be preserved by all means. Strangely enough, the assumption of such a threshold seems equally plausible and justifiable to Kantian as well as to utilitarian ethicists – when it comes to the latter, especially to *rule utilitarian* ones. You see, unshakable respect for moral agents' autonomy, apart from being an utter mandate that emanates straight from pure reason and the moral law as Kantian bioethicist would put it, is also a perfectly functional safety valve in the eyes of those who entertain a fervent concern for utility issues.

An *act utilitarian* would definitely find repulsive or, at best, awkward the assumption that in the case of John blind respect towards an abstract notion such as autonomy should prevail instead of the best interests of the patient. But act utilitarians should consider themselves a rare breed, as Richard Mervyn Hare has argued.[15] In order to be able to successfully determine whether the autonomy of any patient should be respected or overridden, a doctor should be able to judge according to a kind of information that is usually inaccessible to humans: he should be fully aware of his patient's priorities, beliefs and preferences, not to mention the medical particularities of his individual case; at the same time, he should be perfectly sure that the best outcome – not only as far as his patient is concerned, but also from the point of view of the universe[16] – would result from disregarding the patient's autonomy in the face of the anticipated benefits. This, however, calls for accessibility to data and intellectual powers (probably including the power of divination, also) that only seers may possess, but not ordinary people. Since, however, act utilitarians are not Hare's Archangels, but ordinary individuals as all other ethicists, they are entirely justified to entertain strong doubts concerning their aptness to be flexible when it comes to autonomy issues, mostly because "the axiom of universal benevolence that tells us to maximize the good, impartially"[17] is not safe-guarded when respect for autonomy is left upon individual and circumstantial assessment.

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[15] See R. M. Hare, *Moral Thinking: Its Levels, Method and Point* (Oxford: Oxford University Press, 1981), especially chapter "The Archangel and the Prole", 44-64.

[16] When it comes to balancing benefits against potential risks or harms, the real issue is the point of view those are to be assessed from. See Henry Sidgwick's unique suggestion in his *Methods of Ethics* (London: McMillan, 1907), 382: "So far we have only been considering the 'Good on the Whole' of a single individual: but just as this notion is constructed by comparison and integration of the different 'goods' that succeed one another in the series of our conscious states, so we have formed the notion of Universal Good by comparison and integration of the goods of all individual human or sentient existences. And here again, just as in the former case, by considering the relation of the integrant parts to the whole and to each other, I obtain the self-evident principle that the good of any one individual is of no more importance, from the point of view (if I may say so) of the Universe, than the good of any other; unless, that is, there are special grounds for believing that more good is likely to be realised in the one case than in the other. And it is evident to me that as a rational being I am bound to aim at good generally, so far as it is attainable by my efforts, not merely at a particular part of it". For a thorough analysis of Sidgwick's views see Katarzyna De Lazari-Radek and Peter Singer, *The Point of View of the Universe: Sidgwick and Contemporary Ethics* (Oxford: Oxford University Press, 2016).

[17] De Lazari-Radek, *The Point of View*, xii.

In other words, although a patient's best interests would be definitely better served if his doctor disregarded autonomy-related concerns and focused exclusively on the potential benefits for his condition, it is quite doubtful whether this would impartially maximize *the good* from the point of view of the universe: such an attitude might also well result – if generalized, and under circumstances that are not at all rare in the history of mankind – in maximizing overall harm and reducing overall good. Absolute respect for autonomy – in any case and irrespective of the anticipated outcome – is the best tool available to prevent the dreadful possibility of a new Holocaust, or just to avoid be left pray to the caprices of fate and individual moral tendencies or dispositions.

The upshot is that autonomy-related issues in Medical Ethics and Bioethics seem to be more adequately addressed by rule-utilitarianism approaches, and this is probably no less obvious to moral agents – or ethicists – who have a soft spot for act-utilitarianism. After all, in Hare's view, there are only a few situations one can justifiably boast for Archangel-like powers, and only then may one opt for act-utilitarian judgment; autonomy-related issues, however, do not seem to be suitable for such ventures. Therefore, it would call for something more than utility-based objections to challenge the dominant role of autonomy in Medical Ethics and Bioethics.

Autonomy revisited

Anyway, utility-based arguments against autonomy (and vice versa: autonomy-based arguments against utility) probably provide the perfect definition of a poor philosophical debate: they can only convince those who have already been convinced, or those who are about to be; to anybody else, however, they are as good as thin air. In other words, utility concerns may have effect only on utilitarian or utility-concerned ethicists, but by no means on those who pursue such issues form within the Kantian tradition – the latter are anyway steadily fixed on rightfulness. In general, to be rightfully challenged a moral view should be shown inherently defective and inconsistent – and this especially applies to deeply-rooted key ones, such as the views that concern on the one hand the moral standing of autonomy in medical practice, and on the other the very import of the notion when it comes to such issues.

Respect for one's autonomy in its strict sense (the way most Kantian ethicists understand the import of the notion) means allowing one's will to be the ruler of itself, at least when it comes to issues that regard fundamental decisions concerning one's life; in the case of John, this is usually taken to imply that he should be allowed to decide according to his own free will whether he should be treated by means of standard or placebo medication – therefore all relevant information should be available to him in order to make up his mind on his own. However, this only applies in the case John really wants to have all relevant information available; in the case he does not, disclosing such information would mean compromising John's autonomy – this is why the right not to know[18] (or the right to ignorance) has already been included in many codes of medical deontology and conduct. The issue in John's case is that the doctor cannot provide John the option to decide for himself whether he wants to know or not, unless he first discloses all the data concerning the therapeutic options available John would have to decide about whether to know or to ignore; the doctor should tell John something like this: "Your condition may be – almost equally successfully – dealt with either by means of standard medication, or by means of placebo treatment; nevertheless, for the latter to be effective, I need to withhold the truth concerning your treatment and never tell you that you receive sugar pills. Do you agree to be deceived into believing that you are receiving standard medication?" This would allow John the option to claim his right not to know, but in such a case he would already have been aware of the possibility to receive placebo medication, which would render the dilemma altogether obsolete: as I previously mentioned[19], in the case of MDD if the patient knows that he is receiving placebo medication, responsive rates are reduced to such a degree, that this kind of treatment could no more be considered as an option. Both the doctor and the patient seem to be stuck in a dead end: they both will at the same time on the one hand to secure the best outcome for the patient's health, and on the other to keep the patient's autonomy intact (either by disclosing all relevant information, or by granting the right not to know); the issue in this case is that these two – shared by both – wills *are conflicting*. One would have to assume either that moral agents are in general expected to have two conflicting – but equally reasonable – wills with regard to the very same issue, or that one of these wills is not grounded on reason. Since, however, – at least according to the Kantian analysis I discuss here – a moral agent's will is subject to this "special kind of causation", namely the laws of reason, and since reason mandates that when it comes to disjunctive syllogisms of the form *either p or q* not both p and q may be right, one has to assume that whenever any moral agent has two conflicting wills concerning the same issue, one of them should be either irrational or confused. In my view, in the case of John this betrays *conceptual confusion*.

To start with, in the situation described above allowing John's will to be the ruler of itself implies that the doctor should disclose every piece of information *that would be necessary* for John in order to decide according to his own free will – this

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[18] For a thorough discussion of the right not to know see among others Ruth Chadwick, Mairi Levitt and Darren Shickle, eds., *The Right to Know and the Right not to Know* (Ashgate: Aldershot, 1997); also Roberto Andorno, "The Right Not to Know: An Autonomy Based Approach", *Journal of Medical Ethics* 30, no. 5 (2004): 435-440.

[19] See supra n. 14.

[20] See Anne Barnhill, "What It Takes to Defend Deceptive Placebo Use", *Kennedy Institute of Ethics Journal* 21, no. 3 (2011): 219-250.

means *not all relevant* information, but only what would be of key importance to the average patient[20]; this excludes – among others – mentioning extremely rare side-effects, referring to drastic substances, explaining the way the medication will affect one's chemical situation etc. This is simply *unnecessary information* for any patient in order to decide; moreover, information as such could even turn out confusing and misleading. In my view the kind of information John needs to decide whether he would accept the treatment his doctor suggests or not concerns on the one hand its effectiveness and on the other its safety[21]; in other words, he needs to know that the suggested treatment would be at least as effective and as side-effects-free as any other available, or that it offers the best possible balance between effectiveness and side-effects – given that the latter are not unacceptable to him. In that sense, if John's doctor decided not to make John aware of the fact that he would be receiving sugar pills instead of standard medicaments – provided that he would inform John on the fact that the treatment he suggests is slightly less effective than alternative ones, but entirely side-effects free and, therefore, according to his judgment this option is the best available for John's case – he would be doing exactly what any other doctor does when omitting to disclose to his patients information concerning the drastic substances involved in his treatment, or the way these substances would affect the chemistry his bodily condition etc. After all, visiting a doctor is not attending a biochemistry class.

Of course, all the above apply only in the case John's will is to become aware *only* of the facts he really needs to be aware of in order to make up his mind, and not of *all* the information that is relevant to the treatment his doctor suggests. Suppose, however, that John actually *willed – and demanded – to receive all the information* with regard to the suggested treatment, including the kind of substances involved. In his case this seems to mean that John is in the awkward position of having two conflicting wills concerning the same issue: on the one hand he wants to be effectively treated – after all, this is why he has asked for his doctor's services at the first place; on the other he doesn't want to have his autonomy compromised. But this is not true: the average reasonable patient would be justified to demand *detailed* information on all additional data (apart from those already discussed) that are relevant to the therapy he is going to receive only if such information wouldn't jeopardize the potential effectiveness of the therapeutic approaches that would be otherwise available. In the case of John, moreover, having such a will would mean that John wishes to know even though such knowledge would dramatically diminish the effectiveness of the *best* therapeutic option available to him, given that standard medical treatment would only slightly raise responsive rates while at the same time it would almost eliminate John's chances to acquire offspring – which, however, is of enormous significance to John and a key criterion for his

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[21] John, of course, would also need to know that his therapeutic options do not involve something morally questionable or reprehensible.

final decision.

The problem with this situation is that John couldn't be in a position to decide on his own whether he wants to know *everything* concerning his therapy or not, unless the doctor informed him that one of his options are to be administered placebo medication – but then again John *would have already become aware* of what he himself should have decided whether to know or not, and the effectiveness of his treatment would have already be dramatically reduced; and this, in my view, would actually be compromising John's autonomy. It seems that in this case the doctor will have to interpret John's will in order to preserve John's autonomy.

Interpreting one's will is in general an impossible – as well as an extremely risky – task; in my view, however, challenging as it may be, in John's case such an endeavor has quite good prospects to succeed – provided that both John and his doctor are rational, competent adults. The situation is roughly as this:

i. John's declared will is to have his condition successfully treated – we need to keep in mind that in John's case a successful treatment would drastically improve his condition and at the same time wouldn't eliminate his chances to acquire offspring.
ii. The only available treatment that meets with these particular requirements is the one that involves the administration of placebo medication.
iii. Placebo medication can be effective only in the case the patient is unaware of the fact that he doesn't receive standard medicaments.
iv. John's only option to be successfully treated is to be administered placebo medication without knowing.

Now let us assume that next to these, John also wills at the same time to maintain his autonomy intact; let us also assume that to John preserving his autonomy means being disclosed *every piece of information* concerning his treatment options, and not just the *minimum amount* I advocated above – in other words John has a *thin notion of autonomy*. This, however, would entirely eliminate John's chances to be successfully treated. Since these two wills openly contradict each other, only one of them may be sound and grounded on reason; the other would be necessarily misguided, therefore its maxim would be unsuitable to be considered as a potential universal law of nature. In my view this is the case with John's will to have all relevant pieces of information, even those that are not necessary for him to decide, and thus undermine his prospects of having his condition successfully treated. John's will, in that case, actually is to have his condition treated and not treated at the same time; such a will, however is contradictive and, therefore, by no means a rational – and, hence, an autonomous – one. It seems that pursuing autonomy in its strict sense – the thin notion of autonomy – in this case undermines John's capacity to be autonomous.

This is why I previously argued that interpreting John's will is not an impossible task to the doctor: it only takes to judge what a rational moral agent would will in John's case or, better, what a rational moral agent *would be justified to will*. Or, in other words, the doctor needs to decide whether a rational patient would be expected – or, better, *justifiably* expected – *not to claim* his right not to know in a situation as such. Reason mandates that anyone who asks for a doctor's services should be doing so in order to have his condition treated or healed, and not to be fully informed on all the details of any available therapeutic procedure. As I see it, if *tertium non datur* but only: [a] not to be disclosed the full truth and be healed, or [b] to be disclosed the full truth and remain sick, any patient who would opt for [b] would thus reveal a quite confused conception of autonomy.

Conclusion

The morally relevant questions in any case as such is whether [a] not letting the patient know that he will be administered placebo medication is deceiving him and, therefore, infringing his autonomy, [b] if the patient would reasonably will to have *all* information – and not just the *minimum necessary amount* – relevant to the therapeutic options available to him in order to determine according to his own free will, even if he knew that such knowledge would eliminate the prospect of successful treatment.

As for the first question I argued that the doctor in my view is under no moral obligation to inform his patient on every detail concerning the therapeutic options available, but only on those that are necessary to his patient to determine: the prospective responsive rates and the potential side-effects, if any, as well as that none of the available therapies involves something that could be considered morally objectionable or *malum per se*. In the case of John, for example, if the doctor told John that there are two therapeutic options, one with 59% responsive rates but sever side-effects, and another with 46% effectiveness and totally side-effects free, and that both are this should be sufficient to John to decide which one to opt for, even if the doctor failed to inform John that one of the available treatments would involve placebo administration. In such a case nobody, not even John himself if he later became aware of the "full truth", would plausibly or justifiably assume that John was deceived into choosing this option over the other, nor that he would have chosen otherwise if he was informed on the nature of the medication he assented to receive. Therefore, John's autonomy wouldn't have been violated in the case his doctor failed to inform him that one of his options involves placebo administration.

As for [b], I argued that John wouldn't be justified to claim his right to know if this would totally deprive him of the hope to be successfully treated; at least, we could much more plausibly assume that John would claim his right not to know instead. In the case, however, he insisted to be fully informed even to the detriment of his health condition just because he is persuaded that this would be the only way to maintain his autonomy intact, this would reveal conceptual confusion on John's behalf concerning the actual import of autonomy. In Kantian terms John would be willing to be and not to be successfully treated at the same time, which is absurd and, therefore, not an autonomous decision. Since John could never rationally will to know the details that would undermine the possibility of a successful treatment, the doctor is justified to interpret John's rational will and withhold these details without infringing John's autonomy.

The principle of respect for autonomy is the cornerstone of medical ethics, and this is not without a good reason: especially when it comes to health care issues, the autonomy of the moral agent tends to be extremely fragile and vulnerable. Still, respect for autonomy requires a coherent and informed insight concerning the actual import of the term when it comes to health care services: any patient who asks for a doctor's services does so because he is convinced that the latter will do the best he can to safeguard his best interests and provide the best possible treatment to his condition while at the same time eliminating all potential risks. To me it seems almost self-evident that if a patient were to decide for himself, probably he would rather be "deceived" by his doctor and have his condition improved, than have his autonomy preserved but his condition impoverished. This is mostly because the doctor-patient relationship is not an ordinary social one, where autonomy is actually an issue of fundamental moral importance; rather it is a relationship of unilateral dependence based on trust and competence: the patient is convinced that his doctor is trustworthy and competent in such a degree, as to have his health his life trusted in his hands. In such a context, autonomy in the strict sense becomes an irrelevant issue. The upshot is that a moral agent would be justified to decide not to be told the full truth concerning the therapeutic options available to him, but only be disclosed the minimum necessary piece of it, and still keep his autonomy intact.

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