Other Voices

Deception, Pain, and Placebo: *Applying the Brummett-Salter Deception Framework*

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Deception cases are divisive because they nearly always evoke the metadilemma of clinical ethics: a clash between duties (in these cases, truth telling) and consequences (whatever good might come of the lie). Here, I describe a patient case in which members of a medical team and I, as the clinical ethicist, considered deception. While Abram Brummett and Erica Salter publish their framework for the first time in this issue of the *Hastings Center Report*,[1] I was fortunate to have early access to it as a close colleague and through multiple presentations, and I introduced the framework to clinicians who were caring for the patient in this case. Applying the framework that Brummett and Salter have developed to guide physicians in thinking through situations in which deception may be ethically defensible helped our clinical team parse the various issues involved. At each turn, my colleagues and I were able to engage in a more disciplined discourse by using the framework to disentangle various factors at play. The nuances of our case nonetheless illustrated additional ways in which the ethics of deception needs to be refined.

BR was a thirty-two-year-old male patient with multiple medical issues following a suicide attempt three months earlier in which he drank bleach. During an admission shortly after his suicide attempt, a percutaneous endoscopic gastrostomy tube had been placed, but damage to his stomach was allowing bile back into the stomach and out through the stoma, and he was vomiting bile and mucous. After a fainting episode likely caused by intermittent hypotension, BR had been readmitted to the hospital. During this admission, he continuously demanded an increase in his opioid pain medications and would not consent to basic hygiene care, including for the PEG tube, until that demand was met. His physicians, however, were unwilling to increase his dosage because of continued intermittent hypotension and the fact that he appeared comfortable. An assessment of his decision-making capacity found that BR had a reasonably good grasp of the basic facts of his situation but failed to appreciate the possible adverse consequences of increasing his opioid dosage and his risk of infection if he continued to refuse proper care of his PEG tube.

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Discussions among the team, in which I participated, raised the idea of providing a pain placebo. As one nurse put it, "I don't know if it's ethical, but we could just draw his normal dose of pain meds and some saline, and tell him he's getting more, in exchange for him letting us clean him up."

This proposition was immediately controversial, and initial discussion of its ethical merits were convoluted. All of us acknowledged that it was generally wrong to lie, and, indeed, this proved a powerful intuition even as different arguments unfolded. Countervailing justifications favoring the deception were rooted in beneficence-based justifications.[2]

Two features of this case exacerbated its complexity. First, this patient's decision-making-capacity impairments rendered him of liminal status: an incapacitated patient with nonetheless firm and consistent preferences.[3] Second, pain management is riddled with uncertainty because assessment relies on subjective reports, opioid tolerance is variable, and placebo, while deceptive, can be effective.

The Brummett-Salter schema, which identifies four main features of an act of deception—the target of the act, the nature of the information, the nature of the act, and the context of the act—added important nuance to the concepts and guidance from previous literature that assisted us in deciding whether to deceive BR.[4]

The target. The target of the deception in this case was the patient himself. Having the patient, rather than, say, the next of kin, as the target amplifies the justificatory burden a clinician faces for using deception, according to Brummett and Salter's framework, but the fact that BR lacked decision-making capacity lessened the burden. However, there are additional complexities here, particularly with treating decisionally incapacitated patients homogenously. Certainly, wholly delusional patients are routinely lied to because truth has limited utility in the context of a patient who cannot understand or hold on to it. Indeed, sometimes the truth is only agitating to these patients (as when a patient learns that her spouse is deceased only to forget and have to be repeatedly reminded). But for a patient like BR, further refinement of this aspect of the framework would helpfully elucidate the nature of the patient's incapacity: BR was not fully detached from reality, had strong and consistent preferences, and,

importantly, was refusing an intrusion, however slight, on his body. Setting aside the common construal of decision-making capacity as an all-or-nothing proposition, the justificatory burden for deceiving a barely incapacitated patient probably should not be similar to one for a patient who is wholly incapacitated. Still, the framework was helpful for generating this discussion, and our team's assessment was that this patient's standing in light of his cognitive capacities, impaired as they were, resulted in a justificatory burden at least adjacent to that required of an authorized surrogate, particularly since he was objecting to an intrusion on his body.

The nature of the information. Brummett and Salter refine previous models by highlighting how features of the information involved in the deception are morally relevant. They note, for example, that a confirmed cancer diagnosis is more difficult to withhold than a suspicion of cancer. However, we were considering withholding information about a treatment itself. This calls up the justificatory categories outlined in Brummett and Salter's article in table 1, where increased "likelihood and magnitude of good provided or harm avoided" correspondingly strengthen the ethical justification for deception.[5] But predicting likelihood and magnitude also is epistemically fraught, and, just as with diagnostic information, clinicians' confidence in the effectiveness of an intervention may also increase or lessen the justificatory burden.

In BR's case, *epistemic confidence* was relevant in two different ways. First, the team felt that, over time, infection at the stoma was nearly certain (risk was high magnitude), but the severity of the infection was uncertain, both because of inherent unpredictability and because it was unclear whether BR would refuse treatment for said infection (he was not, after all, refusing all interventions, only some). Second, both the assessment of the patient's pain and the effectiveness of a pain placebo were speculative. Both of these epistemic uncertainties amplified the justificatory burden for the proposed deception.

Brummett and Salter's framework calls on clinicians to consider whether the information involved in the potential deception is medical or nonmedical. Our proposed deception was related to a medical decision that BR was making and involved information (dosage of opioids) that he clearly wanted to know. Indeed, BR was keenly aware of his prescribed dosage. Both these considerations also amplified the justificatory requirements for deception.

The nature of the act. Consistent with the frameworks offered both by Daniel Sokol and colleagues and by Brummett and Salter, everyone on our team agreed that it would be preferable to avoid directly lying to the patient. But we could not agree on how to stay on the preferable side of the distinction these authors draw between lying and nonlying deception.[6] It was proposed, for example, that saying, "We are going to do more to help you with your pain," was preferable to saying, "We are increasing your opioid dose." But the act of drawing additional saline to misrepresent the amount of medication would at least have bordered on an outright lie. Relatedly, one might argue that our case hinged significantly on the "duration" or completeness axis that falls within this category of the nature of the act. Given the legitimate placebogenic potential of the intervention, one might read the statement about "doing more" for the patient's pain as a half-truth and therefore an only partially deceptive act. At the same time, even this statement clearly would have been completely deceptive with respect to whether additional opioids were going to be provided, which was the patient's stated concern. In the end, such an act is, at best, highly leading, thereby amplifying the justificatory burden on that axis. Among my colleagues and me, however, the question about nonlying deception was viewed as likely moot since we thought it nearly certain that BR would force escalation to an active lie by asking a direct question about his dosage, particularly given his vigilance about the matter.

The team's lack of agreement about acts and omissions in the context of lying and the fact that the deception we were contemplating would involve some of both (actively misrepresenting the amount of medication and omitting certain words so as to avoid making plainly false statements) suggests that, while helpful, the distinction between nonlying deception and lying deception can remain vague and contentious.

On Brummett and Salter's temporal axis, the justificatory burden of the proposed deception in our case was lessened by the theoretically temporary nature of the deception, which was needed only until discharge, though amplified by the prospect of continual readmissions, each of which might require revisiting the deception plan.

The context of the act. The contextual features of our case also raised interesting questions. The level of coordination needed to accomplish the deception was comparatively low, with only a handful of nurses and a small set of rotating attending physicians needing to carry out the act. However, it was agreed that it was highly likely that staff members would rotate onto the health care team who had not been a part of these discussions and may have significant moral objections to participating in the deception. Those individuals may have amplified the visibility of the deception by talking to colleagues or raising complaints to administration. While the potential for outright scandal seemed relatively low, those of us considering use of the placebo agreed that the visibility of deception could escalate and that this would be largely beyond our control. As Brummett and Salter's article indicates, these factors would increase the justificatory burden.

Ultimately, after working through each dimension of the heuristic provided by Brummett and Salter, we decided that we would not deceive the patient. We concluded that the risk magnitude and severity of infection and other consequences of a lack of hygiene were not sufficient, at least not immediately so, to warrant deceiving the patient

about his opioid dosage in exchange for his allowing the team to provide the basic hygiene and PEG-tube care. In this sense, our decision reflected Sokol's requirement that nondeceptive means of accomplishing the goal must be exhausted before deception can be justified.[7] However, we agreed that it would be important to revisit the question of deception should the patient's condition worsen or should he refuse other, more significant interventions (such as antibiotics for a significant infection).

Much of what clinical ethicists do is attempt to disentangle the various issues of ethically complex cases. As I worked with my colleagues to determine that BR should not be given a placebo, the Brummett-Salter framework was particularly useful for bringing into focus key considerations and helping us disentangle overlapping or competing considerations. This fostered a number of achievements in our particular case.

First, the decision reached was rigorously justified, something that even those who disagreed with it could appreciate. Second, the process of using the framework helped us recognize that, while team members may disagree about whether an act of deception is ethical, our disagreement resulted from slight differences in the various weights we assigned to different aspects of the case, not a wholesale moral opposition; indeed, the team members recognized that they had much in common around this topic even in the midst of their disagreement. Third, the process helped assuage the moral distress of the staff simply by its deliberative nature. It is not controversial to say that lying is wrong. But clinical ethics is a nonideal environment, and its complexities render simplistic moral rules insufficient. But this can thrust clinicians and clinical ethicists into moral chaos. By bringing some order to the chaotic discourse about deception, Brummett and Salter have given us a highly valuable clinical ethics tool.

1. A. Brummett and E. K. Salter, "Mapping the Moral Terrain of Clinical Deception," *Hastings Center Report* 53, no. 1 (2023): 17-25.

2. Ibid.

3. J. A. Wasserman and M. C. Navin, "Capacity for Preferences: Respecting Patients with Compromised Decision-Making," *Hastings Center Report* 48, no. 3 (2018): 31- 39.

4. D. K. Sokol, "Can Deceiving Patients Be Morally Acceptable?," *BMJ* 334 (2007): 984-86; Brummett and Salter, "Mapping the Moral Terrain of Clinical Deception."

5. Brummett and Salter, "Mapping the Moral Terrain of Clinical Deception," 18.

6. Brummett and Salter, "Mapping the Moral Terrain of Clinical Deception"; Sokol, "Can Deceiving Patients Be Morally Acceptable?"

7. Sokol, "Can Deceiving Patients Be Morally Acceptable?"