Placebo in Controlled Clinical Trials

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Identity, Biomedical Technology, and Placebo Effects

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Abstract
This chapter deals with the bioethical and social potential of the placebo effects through three relevant and interconnected cases: identity, biomedical technologies, and autonomy. It is emphasized that Identities are constructed in interaction with or reflection based on our belief in the way other social actors perceive us. According to this stance, our identity and autonomy are built through the influence of the reflections of the other. Having in mind the right of the patient to choose their own identity is part of the principle of respect for autonomy; the placebo effect could be viewed as a powerful means of constructing someone else identity and, consequently, autonomy. Whether or not the placebo is justified, this chapter analyses its potential to transcend facticity and reach.

Keywords: *identity; respect of autonomy; placebo; interactionism; existentialism*

I. Introduction

In the first section on placebo Interactionism, I posit the placebo effect as a part of our identity. The placebo effect is analysed as two-sided expectations related to the clinicians, as well as patients. For this purpose, I used the approach of symbolic interactionism, which explains how a placebo can be comprehended as a deviation and results in a specific inversion of medical and social power. However, understanding our identity[1] during the healing could be constructed on the subjective image of our physical and mental health and well-being in the past and the projection of it in the future.

In the second section, titled Placebo as a Facticity and Transcendence, I dealt with the principle of respect for patients' autonomy and placebo. Considering that the right of the patient to choose their own identity is a part of the principle of respecting

[1] Simultaneously with the term identity, the terms such as self, self-creation, label, and essence will also be used in this study.

autonomy, the placebo effect could be viewed as a powerful means of constructing someone else's identity and, consequently, their autonomy.

From an interactionist perspective, identities are constructed in interaction with or reflection based on our belief in how other social actors perceive us. According to this stance, our identity and autonomy are constructed through the influence of the reflections of the other. Consequently, a placebo could indirectly justify this perspective, avoiding a well-established division between active-control and placebo-orthodox. Contrarily, the existential perspective could claim that the placebo effect can work against the self-defining of an individual, constructing their identity toward self-defined goals and always entailing various social, ethical, historical, and political constraints. Nevertheless, existentialists leave space for the exit from or transcendence of such social facticity. Thus, Placebo and social labels create an existentialist image of the ambiguity of roles, obligations, and restrictions. Ethics of ambiguity can justify such contexts. Such morality rejects any notion of absolute goodness or a moral imperative that exists on its own. In other words, such ethics is a system without absolute values except for man's passion, which is outside of it, concerning which one might distinguish between the useless and the useful. Values come only from our choices. This situation is practically presented at the very beginning of this chapter through two social and medical experiments in mental hospitals. Those cases emphasize that human freedom can exist only in concrete projects and particular circumstances, not as an abstraction. Freedom requires the realization of the concrete ends of specific projects.

The third section challenges the placebo by analysing different biomedical technologies, their capacities, and their bioethical usage. We examined the placebo effect, its possibilities, and justification among the various medical treatments and alongside various biomedical technologies. Considering that new biomedical technologies vary in their time efficiency (temporary/ongoing), frame of application (inside/outside body), and reversibility of the consequences (reversible/irreversible), the question arises: could placebo effects be acceptable or possible in all these aspects?

Finally, we concluded the chapter with the categorical claims that a placebo can be justified whenever a patient, alongside the clinicians, considers it as a truth and a valued exit from the facticity. Consequently, placebos allow clinicians to understand better a patient's first-person expectation of well-being or experience of being in pain.

II. Does the Notion of Placebo Interactionism Make Sense to Begin With?

Continuing the tradition of the Nuremberg Code, the Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects (1964) represents an essential guide for biomedical research on humans.

In the latest version of the Declaration, the use of a placebo is defined in paragraph 33 in the following way:

- The benefits, risks, burdens, and effectiveness of a new intervention must be tested against those of the best-proven intervention(s), except in the following circumstances:
- Where no proven intervention exists, the use of placebo, or no intervention, is acceptable; or
- Where for compelling and scientifically sound methodological reasons, the use of any intervention less effective than the best proven one, the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention
- The patients who receive any intervention less effective than the best-proven one, placebo, or no intervention will not be subject to additional risks of serious or irreversible harm due to not receiving the best-proven intervention.
- Extreme care must be taken to avoid abuse of this option (WMA, 2013).

Considering the previous versions of the Declaration, using a placebo in controlled clinical trials (PCT) is one of the most contested issues in the Declaration of Helsinki (Kimmelman, Weijer, and Meslin, 2009).

Such context is framed with the two opposite standpoints of the usage of PCT. The first one is pro or "placebo orthodox," and the second, con PCT, is called "active-controlled placebo" (Skierka and Michels, 2018, p.2).

The pro account favours placebo-controlled trials even if effective treatments exist, justifying this with higher efficiency and lower costs of such trials. This account mainly uses the Utilitarian argument, with a few suffering for the sake of a large number of potential patients in the future. The opposite account does not support a placebo in the cases where effective treatments exist. It justifies its position by the Deontological arguments that physicians' duty to protect their patients outweighs the benefit of the information for society.

Although both these camps, i.e., ethical accounts, put the patient's well-being first, they do not point out autonomy or, more precisely, the principle of respect for autonomy as an integral part of the patient's well-being.

Furthermore, both accounts ignore the patients' self-defining or constructing parts of their identities during the treatments, such as being sick, being treated, and being fit again (Frank, 2013).

To conclude this short background overview of pro and con stances regarding placebo, what both these camps are missing in their accounts are identity and autonomy as parts of well-being, instead relying on calculating the benefit/harm ratio or, in the opposite case, favour the type of medical paternalism that excludes altruism, solidarity and the right to a self-created identity (Mitrović and Mitrović, 2023) as a motive in PCT.

In the second part of this section, we will analyse identity construction through the placebo effect from an interactionist perspective rather than a medical one. Our justification for that lies in the considerable ambiguity of the placebo, considering its medical, ethical, social, and legal status. The placebo ambiguity could be compared with similar ambiguities in most deviant situations. Deviance here is understood as

not just a statistical unfitness or the deviance measured in terms of functionality and dysfunctionality, but instead as a more complex social and ethical relationship. Using Beckers's (1963) view, deviation could be comprehended as a relationship between the behaviour, the individual, the group, and the wider society.

Becker defined deviance as a social creation in which "social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders." (Becker, 1963). He grouped behaviour into four categories: falsely accused, conforming, pure deviant, and secret deviant.

- Falsely accused represents those individuals who have engaged in obedient behaviour but have been perceived as deviant; therefore, they would be falsely labeled as deviant.
- Conforming represents those individuals who have engaged in obedient behaviour that has been viewed as obedient behaviour (not perceived as deviant).
- Pure deviant represents those individuals who have engaged in rule-breaking or deviant behaviour that has been recognized as such; therefore, they would be labeled as deviant by society.
- Secret deviant represents those individuals who have engaged in rule-breaking or deviant behaviour, but have not been perceived as deviant by society; therefore, they have not been labeled deviant.

From this perspective, the labeling theory is developed. This theory predicts that labeling will vary in status characteristics even when controlling for previous deviant behaviour. The criticism, however, stems from the labeling theory not requiring status characteristics to be the most important determinant of labeling (Britannica, Editors of Encyclopaedia, 2023).

The symbolic interactionist account is based on the notion that people make sense of their social worlds through communication and social interaction - the exchange of meaning through symbols and language (Blumer, 1969). Although there are slight variations, all interactionists agree that the data source is human interaction. Moreover, there is a general agreement among the symbolic interactionists that the perspectives and empathy-developing abilities of the participants are the key subjects of symbolic interaction. One of the most prominent interactionists, Herbert Blumer (1969), defines the basic premises of interactionism in the following way:

- Humans develop their attitudes towards things according to the meanings that the things propose to them.
- These meanings are inferred from the "interaction of one of them from its addressees."
- "These meanings change within an interpretive process" (Aksan et al., 2009, p. 903).

As members of society begin to treat these individuals based on their labels, the individuals begin to accept the labels themselves. In other words, if an individual

engages in a behaviour deemed inappropriate by others, others label that person as deviant, and eventually, the individual internalizes and accepts this label (Blumer, 1969).

> Placebo interactionism, or an interactionist approach to define a placebo, could be understood as a complex relationship between patients' selflessness, physicians' duties, and utility for a broader society.
>
> Consequently, a placebo as a part of identity is not just a reinforcement of a patient's expectation of getting well but also a patient's expectation that clinicians or the broader community accept the same belief of patient health improvement. Such a case is proven by the research on the self and autonomy in medical ethics, where patients can rationalize various practices, e.g., euthanasia, due to justifying their feelings, expectations, and choices in entirely different treatments, i.e., In vitro fertilization (Mitrović, 2020).

Moving back from the introduction of placebo interactionism to physician's view of placebo, some authors claim that in a clinical trial placebo study, some of the patients would feel better, although without objective reasons (clinicians administrate crypto-medicine or skip to administrate it) (Vrhovac, 1977). However, what happens if we change a perspective and use the potential of the same effect in reverse order? What if we choose a deviant approach when testing a placebo?
In other words, those questions help us posit the main aim of this section, which is to investigate whether labels can change an individual's perception of it.

We start straightforwardly with the two cases we can arbitrarily consider as an inverse or deviant placebo.

In Rosenhan's study, the participants, including David Rosenhan (professor of psychology and law at Stanford University) himself, had faked simple voice hallucinations to enter psychiatric hospitals but then acted healthy. The hospitals still diagnosed them with disorders and kept them admitted until they admitted that they had been sick but felt better. The time spent in such a situation ranged between two weeks and two months, proving that the labels given to individuals by the social context determine how they are treated. Later, Rosenhan attacked psychiatric diagnosis and their dehumanizing patient care. In the follow-up study, it was impossible to repeat the same procedure due to the published results (Rosenhan, 1973). Still, Rosenhan agreed with one of the famous psychiatric clinics, which claimed that such an experiment had not occurred inside their institution to uncover fake patients as they first checked at the clinic. The clinic reported about 50% of the patients as fake or suspicious, although this time, Rosenhan had not sent any fake patients to them.

From the sociological perspective, both Rosenhan's studies show how and to what extent the influence of other actors is essential for labeling a particular situation. The image of a patient is built by clinicians, social labels and behaviours, regardless of the actual state of their health. This point proves that placebo and placebo

interactionism are important in constructing identity, or parts of identity that define us as healthy or sick.

To confirm or complete this picture of the inversed placebo, we used the second similar experiment concerning personality and "sanity in insane places" facilitated by Goddard (2011, pp. 831-32); more than half a century later, physicians and hospital staff acted oppositely than in the Rosenhan's experiments and dedicated to the patients their full attention. However, the placebo interactionism part of the study remains the same; the author underlined that after long and brutal attempts to convince the doctors that he was healthy, acts such as taking a pill and acting like a "good patient" finally resulted in discharging the patient who claimed he was not insane.

Both cases show how placebo relates to the patient's self or identity and respect for autonomy. The clinician's image of how a healthy patient should act frames the patient's identity, narrowing the patient's freedom to choose while self-governing his/her acts and chosen identities. However, the clinician's expectations create an inverse placebo effect and allow patients to create the expected image of a good patient, resulting in their discharge.

Nevertheless, it is clear how the placebo effect can disrupt the patient's autonomy. Such restriction of patients' autonomy takes us to the existentialist perspective on placebo, which will be analysed in the next section.

III. Placebo as a Facticity and Transcendence

The principle of respecting patients' autonomy has been the primary issue in medical ethics, notably in terms of the requirement of gaining patients' informed consent for any treatment to be considered legitimate (UNESCO, 2005, p. 77). Nevertheless, there is still an ongoing debate about its exact interpretation and implications. It is not only a matter of dispute how to analyse the concept of personal autonomy in general but also whether and to what degree the resulting specific conceptions of autonomy are suitable for being used in medical ethics in particular (Kühler and Mitrović, 2020). In the distinguished book *Principles of Biomedical Ethics*, Tom Beauchamp and James Childress have analysed the notion of autonomy as a rather generic and, in part, negatively defined: "We analyze autonomous action in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action." (Beauchamp and Childress, 2013, p. 104). One of the reasons for doing so is to acknowledge and accommodate various competing conceptions of autonomy. However, while they indeed explicitly acknowledge the importance of relational accounts of autonomy in this regard, they fail to discuss them in more detail, especially when it comes to addressing their competing implications in comparison to strictly individualistic accounts, like the resulting analysis and assessment of the influence of friends, family, and other social constraints, on a patient's decision-making process. Moreover, given that autonomy essentially refers to the idea and capacity of self-determination and thus includes an authenticity criterion to ensure that it is the agent him- or herself determining his or her decisions and actions, this raises the question of how to spell out this authenticity

criterion and, consequently, the notion of the agent's self in more or less relational or individualistic terms as well (Kühler and Mitrović, 2020). Moreover, this issue is of high importance for this chapter. In the previous section, I have analysed implications of interactionist theories of the self and personal autonomy concerning the placebo practice. The defended position was that in the inverse placebo, the patient's autonomy arises from the constraints of the social labels, where the placebo is finally justified as ethical in specific social and medical surroundings.

The two presented cases of personality and sanity in insane places, Rosenhan's experiment and the subsequent Goddard case, explained how bilateral expectation and social labeling build up the potential for the patients to realize their freedom in challenging circumstances.

Interactionist and existentialist approaches to the constitution of the self and personal autonomy give decisive reasons for interpreting and assessing as (in-) authentic and (non-)autonomous what an insane or, on the other hand, sane patient in the clinical trial, would want, depending on how well it fits in the patient's social label of an insane person, or a subject in a clinical trial.

This section will analyse the issues relevant to our aim, truth, identity, and placebo from the existentialist perspective.

The most compact definitions of Existentialism would emphasize freedom and the struggle for self-creation. The issue with such a broad and diverse range of definitions is difficult to explain. What does and what does not "existentialism" refer to? Today, many contributors are identified as existentialists, and their outputs in politics, arts, humanities, and science are classified as existentialism. However, only Sartre and Beauvoir explicitly self-identified as "existentialists." In surveying its representative thinkers, one finds secular and religious existentialists, philosophers who embrace a conception of radical freedom, and others who reject it. Some regard our relations with others as mired mainly in conflict and self-deception, as well as others who recognize a deep capacity for selfless love and interdependence. Given these disparate threads and the lack of a unifying doctrine, one can distill a set of overlapping ideas that bind the movement together (Aho, 2023).

Nevertheless, existentialism rejects the established view in Western philosophy – the idea of detachment and objectivism, where the subject is detached from their emotional surroundings and capable of judging without subjective influences. More precisely, existentialists argue that we cannot look down on the human condition from a detached, third-person perspective because we are already thrown into the self-interpreting event or activity of existing, an activity that is always embodied, felt, and historically situated.

> Existence is generally grasped through dispassionate theorizing but through a careful analysis of first-person experience, the concrete, flesh, and blood particulars of everyday life, and the feelings, relationships, and commitments that make us who we are (Aho, 2023).

In short, if we try to comprehend existentialists through binary opposition objectivism/subjectivism, it could be defined as a philosophy that begins from the

standpoint of the *engagé* of the individual engaged in life and who confronts the givens of existence.

Speaking about subjectivism, Aho (2023) underlines that Kierkegaard reverses the traditional orientation that privileges objectivity by claiming that, when it comes to the question of existence, one's own subjective truth is "the highest truth attainable" (1846 [1941, 182]). Kierkegaard explains further, "The real subject" "is not the cognitive subject … the real subject is the ethically existing subject" (1846 [1941, 281]). As in the examples from our previous section, the subjective truth cannot be reasoned about or explained logically; "it emerges from the situated commitments, affects, and needs of the individual" (Aho, 2023). Such truth has no rational justification, and no one else can understand it. Such truth is "a truth which is true for me" (Kierkegaard, 1835 [1959, p. 44]).

The subjective truth could be explained or justified in psychological and philosophical accounts. For example, Nietzsche emphasizes the psychological, functional, and pragmatic motivation of believing in objective truth. Such truth protects us from the contingency in our existence. It is incapable of operating with life's contingency. Nietzsche understands that human beings are vulnerable and frightened, and the belief in truth—even though an illusion—has social and pragmatic utility by providing a measure of coherence and reliability. We need these truths for psychological protection, i.e., to help us cope with an otherwise chaotic and precarious existence. "Truth is the kind of error without which a certain species of life could not live. The value for life is ultimately decisive" (Nietzsche 1901 [1968], §493).

For Nietzsche, truth is always related to, or shaped by and positioned in a social and historical context, and it endures only so long as it is socially beneficial. That means that our self-creation, social labels, and various identities last as long as society requests or supports them. Such social facticity of truth and identities results from our compulsion to arrange our surroundings:

> The compulsion to arrange a world for ourselves in which our existence is made possible: we thereby create a world that is calculable, simplified, comprehensible, etc., for us. This same compulsion exists in the sense of activities that support reason—by simplification, coarsening, emphasizing, and elaborating, upon which all "recognition," all ability to make oneself intelligible rests. Our needs have made our senses so precise that the 'same apparent world' always reappears, thus acquiring the semblance of reality. (Nietzsche 1901 [1968], §521)

Still, there is a possibility of transcendence or exit (Aho, 2023), which we find in the previous case of social interactionism, a type of social construction that is not based on the historical people but on some concrete social situation or social role, e.g., the role of the patient in a mental hospital. Such identity or self is not a disembodied mind or a patient's consciousness. It is a relational activity structurally bound up in the clinic's surroundings. In other words, "self and world belong together in the single entity, the Dasein" (Heidegger 1927 [1982, p. 297]).

According to Heidegger's perspective, our identities result from the relational settings of our lives. Such self is involved in the set of meanings. Personal involvement in the world allows objects to affect us in specific ways and situations. However, we are not just mere observers. Our involvement with the objects gives them meanings; we encounter them as meaningful (Heidegger, 1927 [1982]).

Considering constraints of truth and knowledge on the one hand and the relational self, which gives meaning to our world, existentialists generally affirm that human beings have free will, can make decisions, and are held responsible for their actions. However, some social and historical constraints restrict our freedom to do whatever we want.

It means that existence is structured by our capacity to give meaning to our situation based on our actions and choices as our lives unfold. Insofar as we exist, we envision a certain kind of life, assign a value to our identity, and make ourselves into the kind of person we are (Aho, 2023).

When we become aware of our freedom as an inescapable given of the human condition, the awareness is often accompanied by anxiety because we realize that we alone are responsible for our choices and the projects we undertake. There is no moral absolute, divine will, or natural law that can provide guidance or justify our actions. We are, in this sense, condemned to be free because "there are no excuses behind us nor justifications before us" (Sartre, 1946 [2001, 296])

Accepting placebo as a constraint, we are free to exceed or transcend such restriction. In Rosenhan's experiment, placebo was a kind of accepted facticity, i.e., healthy patients faking insanity and, paradoxically, sanity exceeded labels that defined patients. At the same time, the placebo effect enabled their freedom to be accepted and self-defined as either insanity or the state of optimal health. In previous studies, patients' behaviour was a placebo directed toward physicians. Such an inverse placebo does not differ from the regular one. The effects of both are reflected in the patient's behaviour. Double-sided expectations characterize both. The patient wants to be fit, and the doctor wants to find a way to benefit many patients. While with the placebo, the hidden expectations are on the clinician's side, in the inverse placebo, they are on the patient's side.

However, could this practice be justified in medical ethics and the wider community? The existentialists claim that our "essence lies in our existence" (Heidegger, 1927 [1962, p. 42]) or that "existence precedes essence" (Sartre, 1946 [2001, p. 292]).

This suggests that no pre-given or essential nature determines us, which means we are always other than ourselves and do not fully coincide with who we are. As we have seen in the presented cases, absolute freedom of self-creation must be understood as "freedom in situation" (Sartre, 1972 [2008, p. 35]). We are indeed free to create ourselves, but it is also true that our situation already creates us. "Man" is best understood as "a totally conditioned social being who does not render back completely what his conditioning has given him" (Sartre, 1972 [2008, p. 35]). Acknowledging existence as a self-making process does not mean that existentialists deny that there are determinate aspects or "facts" about our situation that limit and constrain us. This is our givenness (or "facticity"), including aspects of our being

such as our embodiment and spatiality, our creaturely appetites and desires, and the socio-historical context in which we find ourselves. Nevertheless, what distinguishes us as humans is that we can rise above or "transcend" these facts in how we relate to, interpret, and make sense of them (Aho, 2023).

The fake patients have been labeled as insane because they claimed they could hear one or a couple of simple words. Nevertheless, they are free to question and give meaning to such labels and project their action into the future. The meanings shape their choices and clinicians' expectations and give the wanted direction to this situation. Neither pills nor the objective diagnosis of insanity shaped their freedom, but their self. They gave meaning to the role or label of sane and insane, which, in turn, identified themselves as sane and insane to the clinicians.

The placebo has worked as the facticity and transcendence. This existentialist perspective broadened the starting interactionist position and explained placebo effects regarding existence, essence, and freedom to self-creation.

In other words, Existence is a reflexive or relational tension between "facticity" and "transcendence," where our facticity constrains us. However, it simultaneously endows us with the freedom to exceed or transcend it (Aho, 2023).

IV. Does Placebo Count Even If It Is Justified?

If we posited that human life is the supreme value of the first order, then almost all the other values from the lower orders can be justified. Furthermore, almost all means can be justified. However, the bioethical approach to new biomedical technologies requires an analysis of biotech effects and their intermediary states, which are essential for the ethics of the means.

This section challenges the placebo ambiguities or deviance by analysing different biomedical technologies, their capacities, and their bioethical usage. Considering that new biomedical technologies differ in terms of "time efficiency (temporary/ ongoing), frame of application (inside/outside body), and reversibility of the consequences (reversible/irreversible)" (Mitrović, 2012, p.118), the question arises: could placebo effects be acceptable or even possible in all of them? Such research could be focused on the existence, nature, and extent of the placebo effect in surgery and the possibility that the placebo effect of the post-surgery and non-surgical effects in clinical/surgical trials (Beecher, 1961; Karjalainen et al., 2022).

Nevertheless, the change in the patient's identity from sick to healed has also been the subject of research through an analysis of the used technologies and experiences of patients or subjects in some clinical trials. The identity is based on the idea that the patient is healthy again, and it is based on the subjective image of well-being (Frank, 2013). This image is formed and relates not to the patient's consciousness of the present state but to the previous image of our ideal of health and often also our physical and mental capacities related to the past.

The image of recovery as a part of the patient's self is the patient's nostalgic image related to their pre-injury memory (Frank, 2013). Thus, the possibility of using a placebo in various medical technologies should consider these patients' capacities.

The possibility of the placebo through the various bio- and medical technologies will be tested on the examples of the pills, deep brain stimulation (DBS), and genetic intervention. For this analysis, we will use the aforementioned three-level scale of application.

The pills could be comprehended as a mean that is on the borderline, yet defined as a mean that is applied inside the body, as well as genetic intervention and deep brain stimulation.

However, the pill has temporary efficiency, while genetic intervention and deep brain stimulation have long-lasting effects. Finally, the usage of pills and deep brain stimulation results in reversible health effects, while genetic interventions do not, e.g., stopping the use of pills and failure in the electric supply of DBS, terminating the effect of the therapy. On the other hand, applied genetic intervention, such as genetic intervention on the germ line, is not just irreversible; instead, it is passed on to all the descendants.

Moreover, a group of authors discuss the changes in the individual identity caused by specific biotechnologies. In doing so, for example, De Grazia, Fukuyama, and others discuss the ethics of using drugs like Prozac, projecting its effects on changing the understanding of personal identity, our actions, and free will. While the first believes that the use of this drug contributes to creativity and "hidden authenticity" (De Grazia, 2000), the second believes that this kind of use is a path to pharmaco-tyranny in which drugs direct the behaviour and free will of individuals in society (Fukuyama, 2003). Juxtaposing the time effect of the used medicine and the free will and identity of the patients, it is clear that a pill can produce a placebo and that patients consider such effects true (Hughes, 2017). However, the effects are time-limited to the period of taking medicine, which depends on the patient's will, i.e., it is possible to stop or start using the pill and optionally fake being a good patient, as in the aforementioned cases.

Authors such as Glennon and Lipsman (Glannon and Lipsman, 2013) discuss the same problems, but the technology is different; about it concerns brain implants. Implants such as deep brain stimulation (DBS) are designed to correct motor and mood deficits, as well as problems related to pathological behaviour. However, their activation (after implantation) does not require visiting a psychotherapist or taking a pill. Considering the former classification of placebo related to various technologies, this type of implant belongs to the mentioned controversial cases of combined technologies. The person who wears it imperceptibly "unconsciously" compensates for deficits in the motor and behavioural aspects of the personality without disturbing the feeling of free will, motivation, and action by taking or not taking the pill. If the device fails, the patient would be aware of some change; that is, he or she would consider that the change in its psychological state was caused not by the original physiological or psychological deficit but by the malfunction of the technology. Since the motives for taking the drug and starting DBS work differ at the point that separates the conscious intake from the unconscious (default) functioning of the implanted device, this kind of technology practically raises the question of whether 1) a placebo is possible by DBS, and 2) whether the patient with such a device has free will, as stated by Glennon and Lipsman (2013, p. 468). According to these

authors, free will and action imply having the capacity to initiate and execute action plans (Glennon and Lipsman, 2013, p. 468).

The device assumes the role of a motivational component in the patient's free will. However, as these authors state, not having complete conscious control over our thoughts and behaviour does not mean that we do not have free will. The control required in free will and action depends on the balance between unconscious and conscious processes, as well as between non-reflective and reflective behaviour (Glennon and Lipsman, 2013, p. 469–470).

Where might this case end? Let us imagine a continuation of the story in a thought experiment. Suppose the doctor were to tell the patient, according to the placebo principle, that they replaced the battery or returned the device to its original function. Would the patient be subjected to the placebo effect? Some studies show a prominent placebo effect associated with DBS in Parkinson's disease. Crossover studies may also help estimate the placebo effect in other medical conditions (de la Fuente-Fernández, 2004).

This analysis shows that placebos differ not only in various medical interventions but also in some of them, like germline engineering, which is impossible.

Such action could be described as a failure placebo, i.e., returning the patient to his old ID, a patient-related deficiency. In this case, the placebo is not supported, nor is the patient's health restored. Although the doctor and the patient can mutually justify a placebo, it is impossible in all medical interventions and trials.

V. Conclusion

Suppose the placebo effect is defined in the terms we operated here, such as deviant, symbolic, interaction, self, identity, and truth. In that case, it should be defined as a social interaction of false and hidden deviants. It could be existentialists' exit or transcendence of constraints such as non-existent medicine or various medicine shortages. It is our own truth of our conditions. Such truth is not always justifiable and comprehensible, but still, it results from the expectations of patients, clinicians, and society. For patients, it is a truth for themselves; they could feel fit. Such truth exists until the moment of the social and medical justification throughout the scientific objectification, ethical justification, and social acceptance. Social acceptance that I was under the placebo effect during one treatment altered my own truth of feeling better into a single social label, i.e., that of a trial subject. From that moment, that becomes once again a facticity. Such a situation results in existentialist conflict or struggle for self-assertion, which evokes Sartre's claim from his famous play *No Exit* that "Hell is—*other people*" (1944 [1989, p. 38]). That means that we are constantly judged to define ourselves through others. In the case of a socially accepted and ethically justified placebo, the "faked" side, that is, patients in the regular and clinicians in the reverse placebo, can define their own truth through the awareness of being subject to the placebo effects. Their primary existence as placebo-treated persons creates the essence of self. Once the trial is over, the trial subject identity is abolished, and the individuals are forced to pursue new self-creation. As in the presented cases, the possibility of a reversed placebo is the only escape from these

constraints, which takes us back to the notions of contingency, ambiguity, and mutability. In this case, the patients appropriate the placebo and, consequently, the new label. They have secured their essence through the self-chosen existence or role of either insane or sane persons. Still, they are not unconstrained. Their transcendence assumes previously accepted labels and roles. It represents a situation that Nietzsche described as the impossibility of knowledge or critique.

> One would have to know what it is to decide whether this or that is real (e.g., "the facts of consciousness"); in the same way, what certainty is, what knowledge is, and the like. Nevertheless, since we do not know this, a critique of the faculty of knowledge is senseless: how should a tool be able to criticize itself when it can use only itself for the critique? It cannot define itself (Nietzsche, 1901 [1968], §486).

In other words, we cannot know or critique the placebo effect as an unauthentic feeling of fitness because we do not know the feeling of placebo or real fitness.

However, how would such ambiguity be justified? By Ethics of ambiguity (de Beauvoir, 2018 [1947])? Existentialist ethics generally begins with the idea that no external moral order or table of values exists a priori. Every person is free to make free choices, but simultaneously, is an object for others. Nevertheless, existentialism is not nihilism. Beauvoir explained ambiguity as a capacity of each of us as subject and object, freedom and facticity. We can take note of ourselves and choose what to do for free. On the other hand, facticity constrains humans by physical restrictions, social barriers, expectations, and the political power of others. (de Beauvoir, 2018 [1947]). From this ambiguity, a coherent ethical account is developed. The account recognizes transcendence and the obligation to help others in achieving their own freedom so that we can realize ours. Thus, one's freedom is his or her essence, but at the same time, freedom is the essence of others. So, we are obligated to help others to realize freedom. My freedom, then, is not free-floating; it is invariably bound up with the freedoms of others.

Although others are often perceived as our own constraints, the placebo ambiguity can be justified through the ethics of ambiguity by acknowledging and helping to realize the freedom of others. This freedom is also comprehended as a free choice of our identity. The freedom to believe and apply the placebo (Hughes, 2017) helps the patients realize their identities as healed persons, resulting in leaving medical, social, ethical, and political constraints.

This study has used the methodology of symbolic interactionism and existentialism, which emerge in medicine and nursing and from gerontology to palliative care. To this end, existentialism and interactionism have informed a move away from the reductive and objectifying tendencies of modern biomedicine to recover the first-person experience of health and illness, viewing the body not so much as a biophysical machine that needs to be adjusted and maintained but as the experiential and interpretative medium of our existence. This shift has not only allowed clinicians to challenge the emergent tendency to medicalise the ever-expanding swaths of human conditions; it makes it possible for the clinician to better understand the patient's experience by getting a sense of "what it means" and "what

it feels like" to suffer when the body breaks down (Aho, 2018; Slatman, 2014; Svenaeus, 2022; Zeiler & Käll, 2014).

However, juxtaposing the last with section IV, it is evident that even if a placebo can be justified, it cannot be attained in all biomedical technologies.

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