Quill & Scope

Volume 7 *Volume VII* Article 9

2014

Emerging Justifications for Placebic Treatment

Tejas Pulisetty
New York Medical College

Emerging Justifications for Placebic Treatment

Tejas Pulisetty

I spent the summer of 2011 collecting data for my global health research in the urban and rural locales of eastern Ghana. Besides learning how to say "Do you have any organic chicken left?" in the native Twi dialects, and how *not* to dance to the music of the pop star Amako, I learned of the depth of an inveterate ethical dilemma.

During the daily eye health outreaches in the rural villages where I volunteered, one of the Ghanaian ophthalmologists would routinely prescribe tetracycline ointments for patients, despite believing that the patients were perfectly healthy. When we asked why, he responded, "They come here because they feel that they need a checkup. When they go home with something in their hands, they feel satisfied and happy that they received a tangible treatment from the clinic."

The reader may sense something amiss here, but at the moment, I didn't think much of it. Perhaps it was merely a cultural difference that I was unaware of—or perhaps the doctor was on to something.

It turns out that clinicians routinely prescribe unnecessary medications much more frequently than was previously known—and this occurs not only in Ghana, but also in developed countries.

For instance, in the United States, it is not entirely impossible to imagine a scenario in which a patient walks into a clinic and the doctor has a diagnosis that is so difficult to make that the doctor ends up giving the patient a medication that they know will not biochemically or physically address the patient's condition. This is confirmed statistically—an investigation of 3,848 patient visits over a one year period to an established general practice revealed that in roughly half of all initial general practice patient-doctor consultations, a firm diagnosis could not be made as a result of the patient presenting with vague symptoms instead of a specific chief complaint.[1] Why, then, would the doctor choose to provide the patient with a medication that is not biochemically or physically proven to address the symptoms? Because such treatments have been shown to work for many decades in a variety of scenarios.

A 1987 British study divided a collection of 200 patients, for whom no clinical diagnoses could be made, into separate groups. One group received honest feedback and was told that the clinician did not know what caused their problems. A second group received false feedback and was not only given a specific diagnosis, but was also told that they would definitely get better in the next several days. Interestingly, this second group was more than 64% more likely to experience an improvement in symptoms than the other group.[2] If this is the case, why doesn't every caregiver do this?

In real clinical scenarios, placebic treatment is a controversial grappling between the bioethical principles of autonomy and beneficence. Placebos are inert substances or treatments that are prescribed for psychological rather than physiological benefit. In order for placebos to work, the personal interactions between a caregiver and a patient must somehow convey to the patient a suggestion of a positive outcome. If the suggestion is unintentional on the part of the caregiver, it is not considered a form of deception.[3] The suggestion may also be honest and intentional yet incomplete. For instance, the physician may say to the patient, "I am prescribing a pill which research suggests can be of benefit to you. In your circumstances, I have reason to believe that it will work with minimal side effects."[4] This can be considered a mild form of deception because the patient is intentionally led to believe that he or she is getting a real physiological treatment instead of a placebo. In this situation, the deception clearly prioritizes beneficence and violates patient autonomy. Or does it?

It can be argued that the decision to give the patient an honest and informed definition of the placebic treatment could potentially dissuade the patient from receiving the placebo, thus leading the patient to choose to go untreated and effectively *eliminating the option* to be treated. Ultimately, this would result in a paradoxical *loss* of autonomy from the patient's perspective.[4] Bennet Foddy, a senior research fellow at the Oxford Institute for Science and Ethics, notes that "whether the patient takes the placebo or refuses it, the pharmacological outcome is the same," considering that a placebo is inert. Furthermore, Foddy states that "the only difference is that in one case, the patient forms a self-benefiting false belief."[4] By this logic, it would seem that prescribing a placebo results in a net gain for the patient. Indeed, the theme here is that the patient's right to refuse a thoroughly-explained and unveiled placebic treatment is overridden by the potential benefits a patient can receive from a placebo and the drug's inert nature.[4]

In further support of placebo use, Professor Foddy provocatively adds:

> *Doctors have a duty to do the best they can to relieve a patient's symptoms. If that means they prescribe a placebo, or even conduct a séance…then there is a duty to do these things. If a doctor can really suggest to a patient that a chant will cure his headache, then it very likely will, and she should ululate it at the top of her lungs…It is a type of deception that patients ought to be thankful for, just as we are thankful when we receive a mendacious compliment from a friend.*[4]

Overall the support for placebic treatments is argumentatively diverse, and the umbrella argument of proponents for placebos is that physicians are obligated to do the best they

can to relieve a patient's symptoms.[5] An interesting observation is that placebic treatments may, in certain cases, be one of the best possible treatments. For example, placebos have been shown to be unusually effective in psychiatric depression as well as irritable bowel syndrome (which may involve a substantial psychiatric component).[5] Proponents also point out that placebic treatments are often significantly less costly than treatments such as antibiotics or diagnostic tools such as MRI, both of which are not always deemed necessary in initial patient-physician encounters.

However, the opposition is just as robust on the other side. Even though placebic treatments are currently less costly than true pharmacological treatments or diagnostic tools, prescription drugs in general add to a national burden of drug costs, and placebic drugs may further contribute to this burden in the future. In fact, it was recently shown that the more expensive a placebo is, the stronger its therapeutic effect may become.[6] Furthermore, prescription drugs, via incorrect dosage or unintended use, have been shown statistically to kill 106,000 Americans per year, and prescribing excessive, costly, and physically unnecessary medications is an obviously condemnable habit.[7,8] Additionally, while emphasizing the violation of basic principles of the doctor-patient relationship, those who oppose and question placebic treatments also contend that such treatments indirectly lead to hazardous results. These opponents further believe that placebic treatment should not be used in a real clinical setting but should be strictly limited to laboratory clinical trials. After all, resorting to clinically unsubstantiated treatments may delay a proper diagnosis of a serious illness.[7] Thus, there exists a solid body of opposition to such behavior by doctors. In fact, the American Medical Association delineated an ethical policy that prohibits the deceptive use of placebos in clinical practice, in which physicians are barred from giving patients "a substance…that the physician believes has no specific pharmacological effect upon the condition being treated."[9] Additional data is needed to better describe the relative amount of opposition and support of placebos by professionals.

One survey revealed that approximately "half of [all] internists and rheumatologists" in the U.S. routinely prescribe placebic treatments for patients with debilitating chronic conditions.[10] In an Israeli hospital, a retrospective questionnaire revealed that 37% of physicians prescribed placebos at least once per month, and 94% of all placebo-prescribers believed they were effective.[11] A Danish survey estimated that 48% of Danish clinicians prescribed placebos more than ten times in a given year, and that 46% believed that placebic treatments are ethically acceptable.[12] A Canadian survey found that 80% of clinicians in one hospital admitted to using placebos at least once in a given year.[13] Finally, a New Zealand survey "indicated that almost all [general practitioners] surveyed would deliberately use a [placebic] treatment under some circumstances."[14]

Regardless of the interpretations of modern data, the strength of the support, or the force of the opposition, placebic treatment will remain an option that is very useful for some patients and less useful to others. Although this debate has historically been level, the modern ethical arguments presented here, in combination with the evidence of positive support by health professionals and students, seems to show substantial ethical rationale and professional support for the use of placebos in clinical practice. Placebos are "the most commonly prescribed drug across cultures and throughout history," and as aforementioned, there is violation of neither patient autonomy nor beneficence in the use of placebos.[2] Although one cannot assert with certainty that the Ghanaian ophthalmologist who prescribed tetracycline that summer should be commended for his behavior, it is apparent that he has done no harm and has not strayed from the societal nor professional guidelines of modern medicine.

REFERENCES

1. Thomas KB. Temporarily dependent patient in general practice. *Br Med J*. 1974;1(5908):625-626

2. Thomas KB. General practice consultations: is there any point in being positive? *Br Med J (Clin Res Ed)*. 1987;294(6581):1200-1202.

3. Gold A, Lichtenberg P. The moral case for the clinical placebo. *J Med Ethics*. 2014;40(4):219-224.

4. Foddy B. Response to open peer commentaries on "A duty to deceive: placebos in clinical practice." *Am J Bioeth*. 2009;9(12):W1-W2.

5. Foddy B. A duty to deceive: placebos in clinical practice. *Am J Bioeth*. 2009;9(12):4-12.

6. Ariely D. *Predictably Irrational: The Hidden Forces That Shape Our Decisions*. New York, NY: HarperCollins; 2008.

7. Braillon A. Placebo is far from benign: it is disease-mongering. *Am J Bioeth*. 2009;9(12):36-38.

8. Institute for Safe Medication Practices. QuarterWatch—Monitoring FDA MedWatch Reports. http://www.ismp.org/quarterwatch/pdfs/2011Q4.pdf. Published May 31, 2012. Accessed December 26, 2013.

9. Bostick NA, Sade R, Levine MA, Steward DM. Placebo use in clinical practice: Report of the American Medical Association Council on Ethics and Judicial Affairs. *J Clin Ethics*. 2008;19(1):59-61.

10. Tilburt JC, Emanuel EJ, Kaptchuk TJ, Curlin FA, Miller FG. Prescribing "placebo treatments": results of national survey of US internists and rheumatologists. *BMJ*. 2008;337.

11. Nitzan U, Lichtenberg P. Questionnaire survey on use of placebo. *BMJ*. 2004;329(7472):944-946.

12. Hróbjartsson A, Norup M. The use of placebo interventions in medical practice—a national questionnaire survey of Danish clinicians. *Eval Health Prof*. 2003;26(2):153-165.

13. Gray G, Flynn P. A survey of placebo use in a general hospital. *Gen Hosp Psychiatry*. 1981;3(3):199-203.

14. Thomson RJ, Buchanan WJ. Placebos and general practice: attitudes to, and the use of, the placebo effect. *N Z Med J*. 1982;95(712):492-494.