

The Ethics of Placebo Prescribing

ANDREW C. MARKUS, B.M., B.Ch.

Abstract

The prescribing of placebos brings into focus the practice of being truthful to patients. The term “placebo” has a generally pejorative connotation in medicine, although the Latin means “I shall please.” More recently, the definition of “placebo” has expanded to include “medication without proven pharmacological activity.” Yet it is known that the use of placebos often leads to substantial improvement. The effectiveness of placebos is a challenging and troubling issue for physicians. **Key Words:** Ethics, placebos.

WHEN I THINK OF THE CHANGES that have occurred in the half century since I entered medical school, three seem especially important: the development of pharmacologically active drugs (I remember prescribing “tonics” frequently in my early years); the development of statistically significant trials; and perhaps equally important, the demand by patients to be given truthful information about their health status so that they can be fully involved in decisions about their care. This is not to say that one should overwhelm patients with this information — one may be “economical with the truth,” to quote a famous phrase used by the UK attorney general in the Peter Wright spy trial — but on the whole, one should aim at being truthful so that patients can make informed choices.

The prescribing of placebos brings these three areas into sharp focus, and this is what I want to deal with in this paper. At the same time, I want to touch on the view held by many of those practicing orthodox medicine, that complementary medicine is a form of organized (or perhaps disorganized) placebo prescribing and, therefore, somewhat immoral.

Dr. A.C. Markus is a Fellow, Green College, Oxford, and General Practitioner, Thame, Oxon, United Kingdom.

Address correspondence to Dr. A.C. Markus, M.A., B.M., B.Ch., F.R.C.G.P., M.R.C.P., Lashlake House, Thame, Oxon OX9 3AU United Kingdom.

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First a case history:

A thirty-year-old farmer was giving his three-year-old son a ride on his tractor, when the boy fell off. He was run over and killed. The mother had told the father that she thought it unsafe for the boy to ride on the tractor, so the father not only lost his son, for which he felt responsible, but found his marriage in trouble.

The father developed severe backache, which did not respond to ordinary analgesics, or to suggestions that the cause was psychosomatic. I was called out one night to see him. He was unable to move due to spasm of his back muscles, and I could think of no alternative, in the acute situation, to giving him an injection of meperidine. The next night the same thing happened, and by the third night I was losing sleep and getting worried about the prospects — the patient’s and mine!

I took him into our local community hospital and requested that the nurses give meperidine during the night, if required. After the first night I decided that I would have to change course, so I prescribed distilled water by injection if he had pain in the night again. The water worked, and I was then faced with what to do next.

I decided to tell him the truth — that he had been given an injection of water in the night and that this had relieved the pain. Fortunately, he accepted my subterfuge and we were then able to start dealing with the

backache as a psychological rather than a physical problem.

I was left with an uncomfortable feeling that I had deceived my patient. However uncertain I was as to what category the treatment belonged to, I felt that the water had been used as a placebo, but that it was also a rational form of treatment in this particular case. It is this dilemma which led me into thinking about placebos in general.

“Placebo” is Latin for “I shall please,” and in medicine it has a generally pejorative connotation, suggesting that it is something given *to please rather than to benefit* the patient. More recently, a lack of proven pharmacological activity has become part of the definition as well. This usage carries with it a suggestion of deception. Yet we know that in placebo-controlled trials of drugs in patients with depressive illnesses, asthma and hypertension, the patients treated with placebos often improve substantially. Thus, the very effectiveness of placebos is both troubling and challenging to us as rational doctors.

Whenever doctors interact with patients, the event has an effect on both parties. Michael Balint coined the concept of “the doctor as drug” and described this effect as part of the doctor’s therapeutic armamentarium (1). So should we consider this a placebo effect? I think not. Any person talking to a friend, or any patient talking to a trusted doctor, may derive benefit from the interaction. This is really the world of counseling and psychotherapy. There is a continuum between, at one end, listening and supporting someone, and at the other end, psychotherapy. We know that such interactions can be of benefit — and also, of course, can do harm. In other words, they have proven effects.

If we accept this restriction on the use of the word “placebo,” we are left with the placebo effect as being related to an intervention, usually the prescription of an oral agent. This fits in with the *Oxford English Dictionary* definition of placebo as “a ‘medicine’ given more to please than to benefit a patient.” But this definition will not suffice, because, as I mentioned before, in placebo-controlled, randomly allocated clinical trials, placebos do work.

Is a placebo then just a possibly effective intervention which has not been proven by scientific method such as a randomized controlled trial (RCT)? Maybe we should start by looking further at what a placebo effect is (2).

Trying to define the placebo effect on an individual basis is impossible. Too many variables

confuse the picture — in particular, the effect of the doctor-patient interaction.

On a more statistically valid basis, the placebo effect could be defined as the difference in outcome between a placebo-treated group and an untreated control group in a controlled experiment, e.g., an RCT.

If we accept that a placebo does have an effect, then why, if some interventions are always less effective than others, should one intervention be labeled “placebo” and another “active”? In other words, doesn’t the fact that a placebo is better than no treatment at all make the placebo an active treatment?

This leads to a definition such as “a placebo is an intervention which is believed to lack a specific effect on the disease, but which is better than no intervention.”

This definition takes an important step forward by including the concept of “belief” rather than knowledge, and belief in a treatment by doctor/therapist/practitioner or above all patient is what placebo effect is about. But what does “specific” mean? Does “specific” in the phrase “specific effect” invariably mean that there is scientific evidence, or even a theory to explain a mechanism of action? We do not know the mode of action of some active treatments which we commonly use, such as lithium for depression. And complementary practitioners do claim to have theories for the mode of action of systems like homeopathy, which may rely on unproved “vibrations” of molecules for their effect. It may be that our labeling of such “alternative” or “complementary” explanatory systems as placebo effects is presumptuous. And it may be that some treatments which we now label as “placebo effects” will be proved to be of benefit and their designations will have to be changed. Had the effect of foxglove extract on heart failure been discovered now, it would presumably have had to go through this acceptance process. Many people consider that ginseng increases general well-being as well as sexual potency, but most doctors would label this a placebo effect. Were this effect ever to be proven by a properly controlled trial, the status of ginseng would change.

Perhaps we have taken this search for a definition far enough. We are left with placebos as being effective for some conditions and for which belief in their efficacy is important.

Turning to my field of general practice, the normal progression of events taught to medical students — “history → diagnosis → treatment” — is often impossible to follow. Several studies have shown that for 40–60% of general practice

patients in the UK, no firm diagnosis can be made (3). Where we are unable to make a diagnosis, we have to move directly from history to treatment. And when the diagnosis is in doubt, there is a much greater likelihood of doctors, not only general practitioners, giving treatment which has no proven beneficial effect and may act only as a placebo. A problem here is that the apparent success of a treatment may mislead the doctor into thinking that the diagnosis was correct and the treatment specifically effective. Yet this may not be true (3). This phenomenon has been labeled “the therapeutic illusion” by K.B. Thomas (3) and may result in unethical consequences. The use of antibiotics in viral sore throats is an example. The patient gets better. The issue here is — does the doctor believe the antibiotic to be effective? — in which case, he has not read the results of trials. Or is he using the antibiotic as a placebo? For either reason, that is, whether the doctor believes the antibiotic to be effective in this situation, or prescribes the antibiotic as a placebo, it would be unethical even if the patient suffers no harm when colonies of resistant bacteria multiply.

It appears that the placebo effect is often used unwittingly, both in general practice and medicine in general. What about the deliberate use of placebos? Should we, as in the case that I outlined earlier, prescribe drugs or procedures which we know are of no specific value if the evidence indicates they are not harmful? In 1970, a British medical authority (4) took doctors to task for “failing to make effective use of a considerable body of scientific evidence on the placebo effect. . . . There must be occasions when an appropriately prescribed placebo will be less harmful and perhaps more beneficial than a complex and incompletely understood drug.”

I consider, with Brown (5), that if doctors “can see placebos — like many other conventional drugs — as broadly effective therapies, whose mechanisms are not completely understood and which tend to be more effective for some conditions than others (and in some people more than others), they can offer placebos both honestly and as plausible treatments.”

We know, for instance, that in people with hypertension, if we take their pressure regularly for a week or two, the blood pressure often comes down without any treatment. This is commonly ascribed to initial “white coat hypertension.” Work done in the early 1990s by Materson at the Veterans Affairs Medical Center in Miami (quoted, but without reference, in Brown [5]) showed that at least 20% of observed patients achieved normal blood pressure after several

weeks of taking placebos. I am not sure how these two groups overlap, but it would seem reasonable to say to patients after an initial period of observation that, in treating their hypertension, there are several options. One of these is to take a tablet which has no known active ingredient, but has been found in some 20% of patients to bring the blood pressure down to normal levels; the advantage of this line of treatment is that it has no side effects. If, after a while, the blood pressure is still raised, other treatments can be tried.

There is evidence that placebos seem to work more effectively in patients who are anxious and of dependent personality (6), so it would not seem irrational to try to tailor the treatment to the personality of the patient — something we often do both with drug use and with referrals — and this could include the use of placebos.

The large number of people who consult “alternative” or “complementary” practitioners of all kinds probably do so in part because such practitioners spend more time with their clients and have no hesitation in using the “doctor as drug” effect described by Balint (1) and to which I have already referred. If we accept the power and ethical use of placebos, we can become less judgmental about these practitioners, appreciating that many of their treatments are successful because of the placebo effect in its widest form. That does not mean that we have to accept the bizarre theories that they sometimes use to explain the rationale of their treatments.

Disease is defined as an abnormal state of the body, e.g., hyperglycemia in diabetes, a broken arm or a chest infection. Illness, on the other hand, the feeling of being unwell, is what brings patients to doctors. This is what people have when suffering from a disease, but also, as I have explained, when they have a condition whose cause we cannot explain. And illness is what doctors have to treat, whether by curing a disease with a specific remedy or by other means, such as using the “doctor as drug” effect, or using a placebo.

Our reluctance to use the placebo effect intentionally probably stems from the feeling that we are deceiving our patients. Going back to the case history I related at the beginning, what I was trying to do was prove to my patient that his pain was psychological and not physical in origin, and the deception involved in using a placebo effect was what had troubled me. On the other hand, if we tell our patients — if I had told my patient — that a remedy which has no proven therapeutic effect is being prescribed, its effectiveness is

likely to be diminished. I am sure that would have been the case with my grieving farmer. So my problem with him was with the deceit involved, rather than with the use of a placebo. A paradox, indeed, but in this case about the ethics of deceit to further a therapeutic end, and not about the ethics of prescribing placebos — in other words, do ends justify means?

When I was discussing this paper with a friend who was a registrar of mine some 15 years ago, he reminded me that I had at one time said to him that it is whether the patient gets better that matters, not the treatment used. Perhaps I should have considered telling my patient in advance that I wanted to use a different pain reliever than meperidine (knowing that what I intended to use was a placebo). But I wonder if the different medicine would have relieved the patient's pain.

With the above reservation, I suggest that one can retain one's honesty and remain truthful with patients. In the final analysis, treatment, including the use of placebos, is a means to enhancing the well-being of the patient.

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