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The American Journal of Bioethics

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t713606739>

Is There a Place for (Deceptive) Placebos Within Clinical Practice?

Amir Raz ^a; Cory S. Harris ^a; Veronica de Jong ^a; Hillel Braude ^a

^a McGill University,

First published on: 09 December 2009

To cite this Article Raz, Amir, Harris, Cory S., de Jong, Veronica and Braude, Hillel(2009) 'Is There a Place for (Deceptive) Placebos Within Clinical Practice?', *The American Journal of Bioethics*, 9: 12, 52 — 54, First published on: 09 December 2009 (iFirst)

To link to this Article: DOI: 10.1080/15265160903320455

URL: <http://dx.doi.org/10.1080/15265160903320455>

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Is There a Place for (Deceptive) Placebos Within Clinical Practice?

Amir Raz, McGill University
Cory S. Harris, McGill University
Veronica de Jong, McGill University
Hillel Braude, McGill University

Recent findings, including our unpublished data, suggest that placebo treatments remain a tool that many clinicians use regularly (Tilburt et al. 2008; Sherman and Hickner 2008; Nitzan and Lichtenberg 2004; Horbjartsson and Norup 2003). Dialogue over ethical guidelines of placebo use in clinical situations is not only needed but long overdue. In their target articles, Miller & Colloca (2009) and Foddy (2009) draw on different sources to support disparate arguments. Surprisingly, however, neither author adequately capitalizes on findings from recent practitioner surveys, which offer a tangible vehicle—albeit a crude proxy—to index the knowledge, attitudes, and patterns of use of placebos within the clinical milieu.

Gleaning placebo insights from randomized controlled trials (RCTs) is problematic. As Miller and Colloca (2009) concede and Foddy (2009) discusses in detail, RCTs designed for drug assessment undermine and underestimate placebo effects. Moreover, RCTs most commonly employ sugar pills and saline injections whereas active, 'impure' placebos generate stronger effects than inert materials. In addition, the problem with drawing placebo response rates from RCTs is not just one of *post hoc ergo propter hoc à la* Miller and Colloca, but one of unjustified use of RCTs to evaluate clinical phenomena. In this regard, the criticism of RCTs for ignoring 'soft data' pertaining to individual patients, including psychosocial factors, may equally apply to our reliance on RCTs to analyze the efficacy of placebos (Feinstein and Horwitz 1997).

Miller and Colloca (2009) advocate for a reductionist view proposing that, similar to the evaluations of medi-

cal drugs, the therapeutic benefit of placebos must meet the rigor of evidence-based medicine (EBM). While their use of EBM may be more of a reference to an idyllic term of art than to an operational concept (Raz & Guindi, 2008), they repudiate the inadequacy of a reductionist model to explain the vast intricacies of placebo phenomena. For example, the reductionist model cannot explain why red placebos stimulate whereas blue placebos calm; why more placebos work better than few; and why more expensive placebos work better than cheaper ones. Referring primarily to data obtained in RCTs and laboratory research, the authors find insufficient evidence to endorse the widespread use of placebos. This sweeping conclusion, however, overlooks vast domains of science—social science. For example, consider psychotherapy where placebo treatments likely elicit significant therapeutic benefit (Wampold et al. 2005).

According to our recent survey of more than 600 academic physicians practicing in Canada, psychiatrists treat patients with sub-therapeutic doses of medication six times more frequently than non-psychiatrists. We actually expected psychiatrists to differ from other physicians because placebo responses and effects often occur more readily when the endpoint of treatment is a change in behavior (Laporte & Figueras, 1994) and sub-therapeutic treatments, unrelated to homeopathy, have their many reasons. For example, most judicious psychiatrists typically adhere to a 'start low and go slow' drug policy consequently beginning with sub-therapeutic amounts and increasing the dosage incrementally. Yet many a psychiatrist often report vast therapeutic effects even with the initial

Address correspondence to Amir Raz, McGill University, Institute of Community & Family Psychiatry, 4333 Cote Ste Catherine Road, Montreal, Quebec, H3T 1E4, Canada. E-mail: amir.raz@mcgill.ca

sub-therapeutic approach. Clearly, psychiatrists prescribe such treatments based on professional experience, clinical intuition, and expectation of patient benefit rather than EBM alone.

Interestingly, the vast majority of physicians surveyed oppose prohibition of placebos, with many believing that ethical means of their use are achievable (Tilburt et al. 2008; Sherman and Hickner 2008; Nitzan and Lichtenberg 2004; Hrobjartsson and Norup 2003). Beyond using placebo treatments, practitioners generally believe that placebo effects are therapeutic, acting through psychological—and often physiological—mechanisms in various types of conditions (Tilburt et al. 2008). Survey results, however, also reveal confusion among respondents in terms of defining what constitutes a placebo. For example, of every four physicians practicing in Canada who report prescribing treatments such as vitamins or sub-therapeutic doses in situations without demonstrated or expected clinical efficacy, only one also reported using a placebo. As such, the role of physician beliefs, though not thoroughly examined in either target article, bears heavily on arguments about placebo-related deception in clinical practice. The use of active placebos or placebo treatments that the physician believes are therapeutic calls into question the need for, or even the existence of, deception in the clinical encounter.

Deception is not a popular word to utter in the hallways of modern medicine. Although behavioral scientists, especially social psychologists, have successfully and rather gracefully incorporated deception into their arsenal of research tools, clinicians typically draw a clear divide between medical practice and experimental research and treat even the most incipient intimation of deception with knee-jerk antagonism for all the good reasons bioethicists have taught us to hold dear. Even social psychologists, however, who use deception as their bread and butter adhere to ethical principles and have invested considerable effort in refining their approach and procedures (Mills 1976). Acknowledging that research and clinical practice may be fundamentally different realms, modern medicine may stand to benefit from what those deceptive social psychologists may be able to teach us. While Miller and Colloca (2009) approach deception as an issue to circumvent, Foddy (2009) is a brave soul who actually speaks the unspoken word.

Any use of deception requires great care and sensitivity. Patients dislike feeling that they have been 'suckers' and that they are inadequate persons. On learning the truth individuals may develop strong feeling of embarrassment and shame or they may feel angry about having been deceived. As a general rule, the more elaborate the deception and the more successful it is, the more likely the patient to feel disturbed on learning the true nature of the situation. In addition, deception implies that perhaps some later debriefing is in order. Debriefing, however, is not simply a matter of exposing a person to the truth. If harshly presented, the truth can be more harmful than no explanation at all. Indeed, the explanation of deception may itself have undesirable effects. In this regard any use of deception in a

clinical setting will likely require procedures that aspire not only to leave patients as informed as possible but also to minimize the likelihood of serious resentment toward the physician, the institution/establishment, or the conduct of medicine. Thus, deception is a messy business; yet it may have its place.

Foddy (2009) describes several clinical scenarios in which the deceptive use of placebos, unsubstantiated encouragement included, is both pervasive and necessary. However, when referring to survey data Foddy minimally, if at all, addresses some of the most commonly stated reasons physicians prescribe placebos: to calm the patient or avoid conflict, and to satisfy patient wishes or unjustified demands (Sherman and Hickner 2008; Nitzan and Lichtenberg 2004; Hrobjartsson and Norup 2003). Foddy (2009) nonetheless argues effectively in favor of deceptive placebos as an ethical means to promote therapeutic benefit.

The placebo effect is a context-dependent phenomenon deeply entrenched in both patient and physician expectations of benefit. In order to develop appropriate and applicable policy regarding the clinical use of placebos, debates over their efficacy and deceptive use must look beyond the model of EBM and contend directly with the realities of current clinical practices. While most physicians likely appreciate the clinical merits of placebos, the absence of guidelines and overarching ethical considerations impede open discussion concerning the appropriate role of placebos in medical practice. The recognition that placebo effects accompany any medical treatment underscores the importance of further research on the mechanisms and determinants of placebo effects and responses.

To move forward, not only must the AMA reconsider its position on placebos but the medical community must consider evidence from all of science—not just life science but also social science. The placebo debate is at a critical juncture—turning a blind eye or prohibiting placebo use are no longer viable options. Ultimately, the ethical issue of prescribing placebos is a function of neither empirical efficacy nor deliberate deception; it must also embrace the relative weight of 'curing' versus 'healing' (Boudreau et al. 2007). ■

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