

PLACEBOS IN CLINICAL CARE

AN ETHICAL PERSPECTIVE

■ D. Leonard Werner, O.D

Abstract

Placebos in clinical care have received less attention in the ethics literature than when used with research. This paper raises the question of whether the use of placebos in clinical care is one of dishonesty or beneficence. A case study is presented in this regard.

Key Words

beneficence, clinical ethics, deception, honesty, placebo

Introduction

A common topic among ethicists has been the pros and cons relating to the appropriate use of placebos in research and, although somewhat less frequently, in clinical care.

In research, the use of placebos in the control group is considered the gold standard. However, recently Suchoff has perceptively identified a confounding element when these studies are reported. He reminds us of the established fact that the placebo effect accounts for a “cure” rate of 30% in control groups and questions why this amount isn’t subtracted from the “cure” rate of the experimental groups. It is quite possible that the same percentage in the experimental group is influenced by those factors that account for the “cure” in the control (or placebo) group. We have no way of knowing exactly how many of those cured actually are the result of the treatment, only that it was statistically greater.¹

A topic in the ethics literature relating to placebos in research is the appropriateness of the use of placebos. A consensus of bioethicists is that the standard of care for the condition, and not a placebo, must be the benchmark with which to compare a new therapy.² To ignore this is comparable to replacing insulin with a saline solution from an insulin-dependent diabetic control group in order to test another therapy.

The use of placebos in clinical care has been a part of medical care for the 2500 years since Hippocrates. He wrote of the therapeutic importance of the doctor having a positive approach in the treatment of a

patient, rather than the need for absolute truth. He felt that the essential issue was the patient’s best interest.^{3,4} However, it is not that simple since the absence of truth can compromise the honest relationship between the doctor and the patient.

When I ask optometric students to identify those attributes of an ethical doctor, honesty is always included. Honesty is the essential ingredient in patient autonomy since a patient cannot consent to any procedure without understanding the risks and benefits. Truth is essential for this understanding to occur.

Beauchamp and Childress define a placebo “as a substance or intervention that the health care professional believes to be pharmacologically or biomedically inert for the condition being treated.” Thus its use therapeutically “involves intentional deception or incomplete disclosure.”⁵

The commonality of the research and clinical issues of veracity is the fundamental principle of autonomy, i.e., patients’ or research subjects’ rights. The patient and the research subject exercise this right with their consent, written or implied. The true meaning of consent mandates the understanding on the part of the subject or patient (or their surrogates) of the risks and benefits that the treatment or study will generate. Truth is essential for consent, and while a consent form is not typically applicable to most optometric care, consent is implied as it is when one has routine dental work.^{6,7}

A doctor is unable to utilize a placebo effectively unless the patient believes it will work. If the doctor does not believe there is a scientific basis for success and he implies otherwise, truth is compromised. An attorney friend is harsher and calls it "fraud."

The case study approach is currently the linchpin of ethics education. A typical case presented to a class or audience would be as follows.

Case study

Dr. Smith is notified that Mrs. Jones wants to see him personally. Mrs. Jones has returned to the office three times complaining to Dr. Smith's new younger associate that she is just not seeing "right" with her new spectacles. Dr. Smith escorts Mrs. Jones into the examination room. After verifying some key findings, inspecting the glasses and being certain that they are fitting properly, Dr. Smith states, "I see the problem. It is one that would not effect most persons, but since you are sensitive to tiny changes I will have my lab make the adjustment." Dr. Smith takes the glasses and instructs Mrs. Jones to return in two days. Later he wipes them, wraps them in tissue paper, and places them in their case. Two days later when Mrs. Jones returns he brings out the glasses, unwraps them, places them on her face gently and states, "You see better now don't you?" Mrs. Jones immediately agrees and is dismissed. The class is asked to react.

Discussion

We all agree that Dr. Smith is administering a placebo, but is it ethical? Clearly he is being less than honest and may be accused of being disrespectful of the patient. Yet, as clinicians we are outcome oriented and this case has been successfully concluded with no harm done. Dr. Smith might defend his approach by saying that in his experience, as well as the experiences of other practitioners, this slight degree of deception is in the patient's best interest and often is successful.

In a study investigating the use of deception by physicians, most doctors placed the welfare of the patient as a higher value than truth telling.⁸ This attitude separates some clinicians from some ethicists. These clinicians would argue that the end justifies the means; harmless deception satisfies Mrs. Jones (and Dr. Smith); she did agree that she was seeing

better. The best interests of the patient and the doctor were served.

The virtue-oriented ethicists disagree. They argue that "the end justifies the means" rationale has been the refuge of much unethical behavior. Additionally they might suggest that this apparent success could conceivably take place without deception. Thus, if Dr. Smith assured Mrs. Jones in a caring and compassionate manner that her eyes are healthy and the glasses perfect in all aspects, the same outcome might have been achieved. This approach employs no dishonesty.

Many treatments have not been scrutinized using accepted scientific procedures. The doctor who relies on his/her knowledge and experience to judge the value of such therapies and then presents a particular one to the patient in a positive manner can be accused of promoting an unproven approach. In this fashion many clinicians of all stripes can be accused of promoting placebo care, although traditionally the use of a placebo requires deception.

However, it can be that the use of deception by Dr. Jones, inherent in the placebo effect, may be that he places a greater value on the another fundamental ethic, i.e., beneficence (do what is best for the patient) than veracity.

When I have presented this case to practitioners, they most often prefer the approach of Dr. Jones, students do so less often. Both audiences invariably raise several cogent questions regarding guidelines. For example, does the use of placebos account for the difference in clinical care outcome success rates among doctors using the same intervention?: where is the line drawn between beneficence and deception?

The underlying questions for clinicians are whether they use placebos, to what degree, and if their comfort zones have changed now that the issue of potential deception has been publicly raised. For students, the questions are have they seen placebos being used by their clinical teachers, and if so, did they believe it was unethical? And, will they use placebos, and to what degree?

The answers to these questions depend on the individual's experience, values, and concept of his or her role as a health care practitioner. Nevertheless, the topic of the use of placebos in clinical care is worthy of public and private discussions.

I hope this article will generate interest and response from the readers.

References

1. Suchoff IB. Placebo. *JBehav Optom* 2001; 12(2):30,48.
2. Rothman KJ, Michels KB. Sounding Board: The continuing unethical use of placebo controls. *N E J Med* 1994; 331(6):394-397.
3. Reich WT. ed. *Encyclopedia of bioethics*. Vol. 1 (revised). New York: Simon and Schuster Macmillan, 1995:142.
4. Reich WT. ed. *Encyclopedia of bioethics*. Vol. 3 (revised). New York: Simon and Schuster Macmillan, 1995:1419.
5. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press, 1994:151.
6. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press, 1994:128.
7. Finkelstein D, Smith MK, Faden R. Informed consent and medical ethics. *Arch Ophthalmol* Mar1993;111:324-326.
8. Novack DH, Detering BJ, Arnold R, Forrow L et al. Physicians' attitudes toward using deception to resolve difficult ethical problems. *JAMA* 1989; 261(20):2980-2985.

Corresponding author:

D. Leonard Werner, O.D.

Distinguished Teaching Professor, State University of New York, State College of Optometry

112 Coccio Drive

West Orange, NJ 07052

Lwerner30@aol.com

Date accepted for publication:

October 12, 2001