

PAPER

The principle of parity: the 'placebo effect' and physician communication

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ABSTRACT

The use of 'placebos' in clinical practice is a source of continued controversy for physicians and medical ethicists. There is rarely any extensive discussion on what 'placebos' are and how they work. In this paper, drawing on Louhiala and Puustinen's work, the author proposes that the term 'placebo effect' be replaced in clinical contexts with the term 'positive care effect'. Medical treatment always takes place in a 'context of care' that encompasses all the phenomena associated with medical intervention: it includes the particular method of treatment, the interpersonal relationships between medical staff and the patient and other factors, including physicians' and patients' beliefs in the power of the treatment. Together, these phenomena can result in a full spectrum of therapeutic effects to the patient—from no effects, to small effects, to large effects. In cases where there are significant therapeutic benefits to the patient, 'positive care effects' may be spoken of. Since the ethical codes of the General Medical Council and the American Medical Association demand transparency with respect to patient treatment and insist on complete openness in 'placebo' usage, the author argues that, as a matter of conceptual rigour and consistency, if the term 'placebo effect' is replaced by 'positive care effect', these ethical codes appear to insist on transparency about all such beneficial components of treatment. Given that this appears to be a counterintuitive obligation, the author concludes the paper with some comments on the clinical consequences of this conceptual revision, including a brief discussion of how this important debate might develop.

The use of 'placebos' in clinical practice is a source of continued controversy for physicians and medical ethicists. The prevailing view among medical ethical bodies is that placebos pose a threat to transparency in medical treatment—the patient must always be privy to information about the physician's course of therapy.^{1 2} Peculiarly, and importantly, for the validity of the argument against their usage, the questions of what 'placebos' are and how they work are rarely raised. It is usually assumed that placebos can work only by explicit deception on the part of the physician and are (somehow) effective because this triggers the patient's (deceived) expectation of recovery. Significantly, however, research into placebos is yet to vindicate the former assumption. Indeed, recent (albeit limited) research seems to support the claim that placebos can work even when patients are informed of their usage.³

In this paper, advancing on the recent work by Louhiala and Puustinen,^{4 5} I propose that the term 'placebo effect' be replaced in clinical contexts by the term 'positive care effect'. As Louhiala and Puustinen argue, medical therapy always takes place in a 'context of care': this context encompasses all the phenomena associated with medical intervention. It includes the particular method of treatment (its mode of administration, colour, size, frequency of treatment, etc), the interpersonal relationships between medical staff and the patient and other factors, including any brand names of treatments and physicians' and patients' beliefs in the power of the treatment.^{6 7} Together, these phenomena can result in a full spectrum of therapeutic effects to the patient—from no effects, to small effects, to large effects. In those cases where there are significant therapeutic benefits to the patient, we might speak of 'positive care effects'.

Given that the ethical codes of the General Medical Council (GMC) and the American Medical Association (AMA) demand transparency with respect to patient treatment and insist on complete openness in 'placebo' usage, I argue that, as a matter of conceptual rigour and consistency, if we replace the term 'placebo effect' by 'positive care effect', it would appear that we should insist on openness about *every* care effect that gives rise to beneficial effects. Indeed, mounting evidence indicates that the communication style employed by the physician can be a particularly effective (that is to say, valuable) component of such positive care effects. Certainly, the necessity of explaining and justifying the therapeutic employment of, for example, particular physician communication styles appears counterintuitive. However, I assert that the point of issue here is the prevailing medical ethical stipulation of *complete* transparency in clinical practice. It may be that some clinical practices should be exempt from such transparency; the need for debate as to why this should be the case should, at the very least, be acknowledged. The aim of this paper is therefore the relatively modest one of highlighting the implications of the GMC's and AMA's ethical stipulations when we adopt a more conceptually appropriate understanding of the term 'placebo effect'. While it is beyond the scope of this paper to examine in detail how the medical community might appropriately respond to the issues raised herein, I conclude the paper with some comments on how we might begin to develop that important debate.

FROM PLACEBOS TO POSITIVE CARE EFFECT

At the outset, we need a clear understanding of what is meant by the term 'placebo effect'. In this paper, I endorse Louhiala and Puustinen's contention that the term 'placebo effect' ought to be eliminated from clinical contexts. They assert, 'when we refer to the phenomena that take place during the consultation and lead to beneficial therapeutic results while the treatment given has no apparent causal connection to the outcome, we suggest that the phenomenon be called not the *placebo effect* but a *care effect*'.⁴ In support of this view, Louhiala and Puustinen argue that the term 'placebo effect' is often—problematically—interpreted as the result of 'inert controls' rather than the result of a specific medical treatment. As they argue, this is something of a contradiction in terms: for something to have an effect, it cannot be the result of an inactive agent.

Louhiala and Puustinen note that—unless the patient is unconscious—there is always a 'care effect' present in every therapeutic context. It is the phenomena associated with this context—in contrast to the specific treatment mechanism that is provided to the patient—that may produce additional (even therapeutic) effects on the patient.⁴ Louhiala and Puustinen argue that the term 'care effect' should be interpreted as 'small or even negative with respect to the therapeutic intention, but it can never be excluded from the therapeutic encounter'; yet they also contend that 'the terms care and care effect have neutral or even positive connotations (eg, of concern and responsibility)' and likewise, 'just being acknowledged, heard, understood, assured and comforted can be very alleviating in itself'.⁴ It is clear, then, that by 'care effect' they wish to embrace a spectrum of care and responses to it. However, this only takes us back to the drawing board. Louhiala and Puustinen have thereby included the 'nocebo effect', *no effects* and the 'placebo effect'—that is, they have included negative responses to care, no responses and positive responses. The term 'care effect' as a replacement term for 'placebo effect', as stipulated by Louhiala and Puustinen, is so loose as to be redundant; instead, a more appropriate terminological successor for the 'placebo effect'—one which is in keeping with their careful conceptual clarification—is the term '*positive care effect*'.

What, then, are the factors that may comprise these positive care effects and what explains these effects? As noted, among other factors, research shows that the method of treatment has an impact on its success: patients respond better to larger 'inert' pills than smaller ones⁸; patients fare even better if told to take such pills four times a day compared with twice daily⁹; 'inert' pills make for less effective responses than 'inert' (eg, saline) injections.¹⁰ The colour of the pill also has an impact on the valence and size of the response^{11 12}; treatments are more effective as analgesics if they are recognised brand names¹³; similarly, it is more effective to tell the patient that one is injecting a painkiller such as morphine than doing so surreptitiously.¹⁴ Furthermore, individuals taking part in medical trials are more likely to fare better simply by dint of participation (the 'Hawthorne effect').⁷

It appears that these varied cues in the therapeutic encounter induce an expectation of recovery on the part of the patient, which, in turn, results in beneficial therapeutic effects. Classical conditioning can play one such role in inducing such positive effect.^{15 16} Our conditioned associations with medical phenomena such as pills, injections and so on cause the (subdoxastic) 'expectation' in patients that they will recover and this, in itself, appears to induce therapeutic effects.¹⁷ Recent research shows that such conditioning is mediated by response

expectancies on the part of the individual and these can be affected by other sources of information, such as expectancies communicated by the physician.¹⁷ In the next section, I will focus on the particular verbal and non-verbal cues that are important in physician—patient communication and that give rise to positive care effects.

PHYSICIAN COMMUNICATION AS THERAPEUTIC

A growing body of studies indicates that cognitive factors in physician—patient consultations significantly impact on health outcomes. Typical cognitive factors include providing clear explanations, asking questions of the patient and allowing the patient to ask questions, and giving adequate information about the treatment. Such strategies are part of received wisdom about the importance of providing open and honest information to patients.

However, socioemotional factors are also vital in patient communication. In fact, numerous studies indicate that such factors represent the most important aspect of physician communication.^{18–23} Key physician attributes include empathy, tone of voice, ability to listen and not interrupt the patient, and ability to provide a warm, reassuring and hopeful demeanour. In this relationship, the patient appears to perceive that the physician is approachable and understands his condition (both physically and phenomenologically) and that he (the patient) can be positive about his outcome.

The physician's style of communication can promote a sense of empowerment among patients by encouraging them to believe that the situation is optimistic and that their actions will promote recovery. Studies indicate that 'a sense of control over a situation, even if the individual actually has no control, has a positive effect on health'.²⁴ The tone of voice of the physician, her tendering an empathetic concern on behalf of the patient and conveying a level of hopefulness helps to foster the patient's expectation that he can expect to recover. Research into the neurobiological and biological mechanisms of action for these effects is ongoing⁶; nonetheless, studies repeatedly demonstrate the important role of the physician in steering communication and fostering improved patient outcome. It should be emphasised that findings show that such physician communication styles do not merely increase subjective patient satisfaction (although this is certainly an upshot of what has been dubbed the 'therapeutic alliance'); rather, we find greater patient compliance with medications and medical advice, the keeping of appointments and use of medical services as well as improved physically determined health outcomes.¹⁵ A meta-analysis of 30 years' worth of patient treatment found that 'the cornerstone' of patient compliance with medication is professional empathy.²⁴ This research is highly important: medication non-compliance is a major public health problem. The WHO estimates that only 50% of chronically ill patients in developed nations adhere to medication compliance. The health and economic fallout as a result are massive. It is estimated that 125 000 people die in the USA annually simply as a result of failure to take prescribed medications²⁵ and the financial burden is estimated to be over \$100 billion each year.²⁰

Specific studies on the significance of physician—patient relations help, more precisely, to illuminate these issues. Two studies on heart surgery patients found that the *quality* of the physician—patient communication had a significant impact on outcome^{26 27}: in the groups where the physician adopted a 'friendly, tactful and supportive communication style' and asked patients about their own understanding of their stay in

hospital and the procedures that would occur, it was found to produce 'substantial improvements in the two objective measures of clinical outcome—incidence of one major type of complication—namely post-surgery tachyarrhythmia, and care level adjusted duration of stay in hospital'.²⁰ Indeed, the *emotional quality* of the communication was exclusively cited as 'the true causal effect', which not only brought about these results but also increased patient satisfaction and the ability to adhere to the self-administered breathing exercises that they were instructed to adopt. Notably, these modest 'interventions' (qua communicative strategies) reduced the post-coronary surgery hospital stay by an average of 2 days.¹⁹

Equally impressive results have been found for cancer patients' quality of life and subjective experiences following improved socioemotional communication by physicians. In a recent study, cancer patients' satisfaction was best predicted by physicians' affective tone and empathetic behaviour. Correlatively, low patient satisfaction was predicted by negative affective tone²⁸: anxiety and depression, as well as poor psychological adjustment to cancer, have been implicated in *inferior* socioemotional physician communication styles.²⁹ Moreover, depression has long been recognised to affect patient outcome in cancer and heart disease.^{30 31} While specific research into negative socioemotional effects is ethically objectionable (certainly in cases of chronic illness),¹³ harmful reactions associated with pessimistic expectations that can be induced by physicians—the so-called 'nocebo' effect—have long been identified as medically relevant and significant. Experiments show that a range of negative responses can be generated by (pharmacologically inert) sugar pills if physicians provide low expectations about recovery and describe side effects of the 'medication' in question.^{32–34}

This growing body of research corroborates the results of a randomised controlled trial, conducted two decades ago, on the effects of physician–patient interaction for chronic disease. This trial involved patients with ulcer disease, hypertension and diabetes. In this study, increased information gathering by patients and more dialogue by patients (as opposed to the physician), as well as increased expression of emotion by physicians and patients during consultations, predicted better physical recovery and subjective evaluations in follow-up examinations.³⁵ In the patients assessed, the investigators found that diabetic patients better controlled their sugar levels and that those with hypertension had significantly improved diastolic blood pressure. As the authors note, these findings support the claim 'that patients "aren't just saying" that their health is improved'.³²

At least one study goes so far as to claim that the primary medical interview is the most important procedure that physicians perform.³⁶ It also seems that current communication practices leave plenty of room for improvement. Research shows that '50% of psychosocial and psychiatric problems are missed, that physicians interrupt patients an average of 18 seconds into the patient's description of the presenting problem, that 54% of problems and 45% of patient concerns are neither elicited by the physician nor disclosed by the patient'.¹⁵ If physicians are to offer the best care possible for their patients, it is clear that they need to adopt the sorts of communication styles described in this growing body of literature.

THE ETHICAL REQUIREMENT OF OPENNESS

The medical ethics codes of the GMC and the AMA are now stringent about the importance of openness in treatment among patients. It is worth reviewing the ethical codes of conduct of

these medical bodies thoroughly. Their claims have important implications in light of our conceptual analysis and replacement of the term 'placebo effect' by the term 'positive care effect'.

The GMC declares that, 'You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research'.¹ The GMC asserts:

All healthcare involves decisions made by patients and those providing their care...The principles apply to decisions about care: from the treatment of minor and self-limiting conditions, to major interventions with significant risks or side effects...³⁷

Furthermore, the GMC stipulates that physicians,

Should not make assumptions about:

- the information a patient might want or need;
- the clinical or other factors a patient might consider significant.³⁸

The AMA has similar strict guidelines about transparency with regard to treatment:

The practice of withholding pertinent medical information from patients... is known as 'therapeutic privilege'. It creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully... Withholding information from patients without their knowledge or consent is ethically unacceptable.²

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient...The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic policy in both ethics and law that physicians must honour...³⁹

Patients should receive guidance from their physicians as to the optimal course of action.⁴⁰

Both the GMC and the AMA regard the provision of information for optimal treatment as an ethical imperative. It is no longer deemed acceptable to withhold any such information from the patient in a paternalistic manner. This has repercussions for the employment of 'placebos' in clinical practice. The AMA issues the following guidelines:

In the clinical setting, the use of a placebo without the patient's knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient.

Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use.⁴¹

In light of the GMC and AMA guidelines, the conceptual re-appraisal of the term 'placebo effect' (somewhat counterintuitively) necessitates that physicians are open and honest about those care effects that elicit therapeutic benefits to the patient. In short, *if* these ethical codes are to be upheld, it means that physicians need to declare the relevant factors that can play a significant role in improving recovery—not least, the physician's own communication style.

THE PRINCIPLE OF PARITY

Of course, merely substituting the term 'placebo effect' by 'positive care effects' will not bring about clinical and ethical

adjustments. Rather, the medical community needs to deepen its understanding of the variety of components that give rise to such therapeutic benefits to patients. How the medical community chooses to challenge the emergent tension that results from (i) providing utter transparency in treatment and (ii) a correct understanding of the components that comprise the 'placebo effect', is a question that needs to be addressed. While the particulars of that debate are beyond the scope of this paper, we can open the discussion by helping to locate some key issues.

At the outset, we can note that physician transparency with regard to 'placebo pills' is overwhelmingly regarded as a moral imperative in the literature. Deceptive placebos, it is argued, interfere with a patient's ability to make informed decisions about future medications. If the medical community wishes to uphold this stance, it needs to ask: given the potential therapeutic benefits of the components that comprise positive care effects, including certain aspects of physician communication, should we expect physicians to be candid about all of these other factors too?

One response to this tension might be to argue that patient trust is more vulnerable in the case of 'inert' pills than in the case of, for example, various physician communication strategies. Compare the following:

1. Patient trust can be jeopardised if patients are prescribed 'inert' pills by the physician but are not informed that these prescriptions are 'inert'.
2. Patient trust can be jeopardised if patients are subject to certain communication strategies adopted by the physician but are not informed that they are being subjected to such communication strategies.

While it certainly seems outlandish to suggest that physicians ought to ask permission before adopting socioemotional communication styles,⁴² it might be contended that, *if we prize openness and honesty, patients ought to be made aware of the importance of physician-patient relationships especially if physicians are not doing everything in their power to improve patient outcome.*

Arguably, however, the issue of intuitions is the very point: the defender of current clinical practices might counter that it is part of common sense or 'folk medical' wisdom to expect the physician to adopt a friendly bedside manner. It is not part of any such wisdom, so this critic might assert that physicians should be expected to prescribe 'inert' medication. Yet, quite aside from the notion that we should be hostage to 'common sense', it is clear that folk wisdom about 'bedside manner' is decidedly underinformed about the importance and outcome effects of particular physician communication strategies. It is certainly not part of general knowledge, for example, that heart rate, blood pressure and even speed of post-coronary surgery can be vastly improved as a result of a physician's manner. Moreover, if more patients were aware of the importance of the socio-emotional dimension in medical consultations, arguably there would be greater public scrutiny and demand for improvements in physician interactions. Indeed, it is feasible that grave damage to patient trust might ensue if physician communication techniques lag behind public awareness of the importance of these practices.

The critic might rejoin that, although research has demonstrated the difference between different 'communication strategies', communication is not a 'tool' that the doctor uses like a drug (or an 'inert' drug). What would it mean, in practice, for a physician to begin the consultation by saying, "I would like to use a communication strategy in which I am open and empathetic, but you don't have to accept it?"

To begin with, the issue of whether such communication tools can be viewed as akin to drugs or 'inert sugar pills' is *exactly the point of issue*: the critic, in this instance, is merely begging the question against the conceptual clarification of the 'placebo effect' which has been offered. Second, while there is certainly more to relationships than learned techniques, this does not undermine the key issue, which is that the quality of relationships may have a measurable impact regardless of whether those qualities occur 'naturally' or have been acquired. Moreover, it is certainly possible to acquire such communication skills, which are, as a matter of course, taught to medical students. Such 'communication strategies' are patently viewed as a means to an end and as such we are entitled to call them learned 'tools'. Certainly, training in other client-centred professions is not in the least bit reticent about the notion of employing 'communication tools'.

Nonetheless, while the case might be made for the importance of patient awareness with respect to physician communication styles, the appropriateness of providing this information in the clinical encounter might be disputed. This leads to questions about the correct context in which to provide treatment transparency to patients: if not in the consulting room, perhaps this ought to be achieved, educationally, elsewhere. The issue of how any such educational campaigns might ensue needs to be addressed.

Moreover, this still leaves unanswered the question of whether (and how) physicians should be open and honest about other components that comprise 'positive care effects'—that is, factors such as the therapeutic benefits of prescribing brand name medication; the colour, size and frequency of prescription pill ingestion; and the method of administration of treatments (whether syringes, surgery or high technology are involved). Is it the role of the physician to draw attention to these factors? Given that patients' beliefs in the power of particular treatments can be therapeutic, we surely cannot demand of physicians that they second-guess patient perceptions. Again, it might be argued that the ethical principle of treatment transparency should be bolstered by wider public educational policies. Yet, there may still be an important role for physicians in helping to educate patients about such issues. Certainly, as the GMC's and AMA's ethical codes stand, they potentially place the *entire* burden of communicating positive care effects on the shoulders of the physician.

CONCLUSION

If we hold openness and transparency as key principles in medical ethics codes, being informed that the behaviour of one's physician is significant in one's prognosis and that one's physician may not be employing strategies that will improve (or may even impede) progress are surely issues of grave concern. The medical community must ask itself: is a physician negligent if she does not treat a patient in a certain manner and is it known that this has negative implications for patient outcome? If we answer affirmatively in those cases where physicians fail to provide correct pharmacological treatments or speedy referrals to specialists, why would we answer negatively in the case of communication?

The intuition that we should avoid transparency with regard to such significant components of treatment arguably focuses on an overly narrow model of illness: on such accounts, disease is perceived as a purely biochemical or biological dysfunction and it is the role of the physician to treat it as such.⁴³ This model finds its roots in the philosophically and empirically redundant, even if 'commonsensical', Cartesian distinction between the

physical body and non-physical mind.⁴⁴ It is clear that physicians need to embrace a much more sophisticated understanding of the mind–body. They need to take into consideration the phenomenological aspects of illness and adopt a more integrated medical approach: one that does not ignore human psychology as an embodied state.⁴⁵

The modest task of this paper has been to highlight that discussion of the ethics of ‘placebos’ is morally and intellectually barren unless significant factors in the context of care—including the behaviour of the physician—are also considered. Until the medical community is candid about—among other factors—the effects of physicians’ behaviour on patient outcome, it cannot live up to its own ethical dicta. The debate about how best to inform the public about important aspects of patient treatment and care is one that needs to begin.

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