ETHICS FORUM

Placebos and Treatment of Pain

The Case
A 52-year-old female patient, with a long history of chronic low back pain treated over time with various modalities including, recently, opioids, goes on Friday evening to the emergency room for, she says, “excruciating, paralyzing, back pain.” The house officer working her up finds that she just ran out of the pain medications she was previously on; his evaluation is totally negative; the patient requests IV meperidine for her pain. The house officer agrees verbally to the patient’s request, but, instead of injecting meperidine, gives her a 2-mL syringe of normal saline IV “to see if it will work.”

Is this treatment acceptable?

Opinion #1: Mark Sullivan, MD, PhD
No Place for Placebos When Treating Pain
This treatment is not acceptable for two reasons. First, placebos have no clinical diagnostic value. Second, this deception of the patient is damaging and unjustified.

First, response to placebo does not prove that pain is unreal, imaginary, or psychogenic. There is no special type of pain that responds to placebo. Even when there is clear evidence of tissue damage, many patients report relief from pain with placebos [1,2]. There is no special type of patient that responds to placebo. Researchers searched for many years to define the “placebo responder” to no avail. Our latest understanding of placebo effects point toward suggestion, expectation, and desire for relief as determining the magnitude of the placebo effect [3]. These are properties of the therapeutic situation, not durable properties of the patient. The same individuals may exhibit a placebo response under some conditions but not under others. Placebo effects are not imaginary, nor do they operate only through the imagination. We now understand something about the neuroanatomy [4], pharmacology [5], and physiology [6] of placebo analgesia. These studies have demonstrated these analgesic effects to be examples of endogenous pain modulation within the central nervous system, at least in part mediated by endogenous opioids [7]. Thus, analgesic responses to placebo clearly should not be used to invalidate a patient’s pain complaints.

Second, patient deception is permissible only in rare circumstances and with adequate justification. There is broad legal and bioethical consensus that patients must be informed and provide valid consent before medical treatments are administered [8]. Patients are entitled to refuse any and all medical treatment if they possess adequate decision-making capacity to do so. Deception of patients about clinical treatments violates the rights of patients to consent or refuse treatment. Deception of patients is, thus, a harm that should be avoided unless there are clearly greater harms to patients that can be avoided through this deception.

In placebo-controlled clinical trials, patients consent to the possibility of receiving a placebo rather than the active, experimental treatment, though even this is controversial. Since the Declaration of Helsinki by the World Health Organization in 2000, it is generally accepted that harm to patients is limited, since the alternative active treatment is unproven and there is substantial potential benefit to future patients of a scientifically valid trial [9]. Furthermore, in these trials, patients are deceived only within the confines of the trial to which they have consented. At the completion of the trial, they are fully informed about the nature of the treatment they received and are free to seek the treatment of their choice.

The clinical use of placebos involves a more pernicious form of deception. Here, there is no countervailing goal of scientific knowledge. The above case describes the use of placebo to invalidate a patient’s pain. The clinician acted as if he was acting in the patient’s interest, but he was actually trying to trick the patient and deny her treatment. Studies indicate that the patients most likely to receive placebos for such purposes are those that are disliked or distrusted by their caregivers [10].

Management of chronic pain in the emergency department can be a difficult and contentious experience for both patient and physician. It is not
the best setting to address the complex biological, psychological, and social elements of chronic pain. But it is important not to indulge in pseudoscience and patient deception. Some other means of treating this type of patient or temporizing until the patient can be seen in clinic must be found.

References

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Opinion #2: Judith A. Paice, PhD, RN

Unacceptable Standard of Care

The case presented illustrates a number of dilemmas faced by clinicians treating people with chronic pain. Several red flags are raised: The absence of physical findings, the patient running out of prescribed medications, and the request for IV meperidine. These signs might lead some to conclude that the patient is an addict or drug seeking. Yet there is more to the story, as any clinician working in the field of pain knows too well.

Physical findings are not always apparent in people with chronic low back pain. This absence does not negate the existence of pain. Secondly, our assumption may be that the patient used up her supply of pain medications earlier than prescribed, and that indeed may be the case. However, other factors may explain why she ran out of medications. The pharmacy may have only partially filled the prescription (a common phenomenon, particularly in pharmacies that are reluctant to carry larger stocks of opioids). Although some pharmacies contact the clinician when unable to fully fill a prescription, many do not. Other reasons for running out of medication include the patient not having understood the schedule for taking the medication. Or an insufficient number of tablets of the drug may have been ordered. When the prescription reads “every 4 hours as needed,” the monthly supply should equal 180 tablets. Unfortunately, this amount is rarely ordered. Additionally, she may not have understood the legal limitations of ordering Schedule II narcotics, assuming that a telephone call might result in a refill. Upon finding this to be impossible, she sought assistance in the emergency department. Finally, a request for IV meperidine may reflect a prior successful attempt at pain relief for this patient, rather than some sign of addiction or drug seeking. There are many plausible reasons for the patient’s report, and all require additional questioning, and in most cases, education to avoid future episodes.

The treatment employed by the house officer is not only unacceptable by today’s standards of good medical practice, but the injection does not answer any diagnostic questions (does she have real pain?) nor does it provide a therapeutic intervention. Clinical practice guidelines and position statements regarding the use of placebos strongly recommend against their use, arguing that the practice is deceptive and violates trust between patient and professional. The use of a placebo, in this case, will only delay the delivery of more appropriate treatment for this patient (and likely, the other patients waiting for beds in a busy emergency department).

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