DEBONAFIDE EFFECTS VS. 'PLACEBO EFFECTS'

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The deliberate prescribing by physicians of what are assumed to be inactive substances for treating illnesses is centuries old. Originally knowledge of physiology was crude and doctors had only a handful of powerful, nature-derived, 'pharmaceutical' agents (e.g. ethyl alcohol, morphine, quinine, belladonna) to use medicinally. These had been stumbled upon as extracts of juices squeezed from plants, fruits, leaves and flowers and were often referred to in 'common folklore'. Most were demonstrably very potent – even dangerous. They generally targeted specific organs of physiologic systems. 'Good medical practice' in the Dark Ages and Renaissance embraced a host of other quite bizarre treatments for the ailing body. Among these, bloodletting was the most notorious travesty based on illogical body-chemistry, but there were hundreds of other chimerical procedures and medicines for cures, and these also persisted through the centuries.

In that era, in order to please the patient, desperate physicians would sometimes also prescribe or administer a fake potion or manipulation that they 'knew' had no possible benefit. So was born the designation 'placebo' (Latin for 'I will please') for such a 'fake' treatment. Gradually the term became pejorative.

In the middle of this century, Modern Medicine transferred 'placebo treatment' to any deliberate use of an inert substance, particularly in double-blind drug research. In randomised double-blind studies, one cohort (the 'placebo group') receives identical looking capsules or tablets of an inert substance (e.g. sugar). It is essential that none of the randomly-assigned participants can recognise which of the capsules are either the placebos or the test drug until the official final code-breaking ceremony.

Similar procedures are attempted, with only more modest success, in investigating other forms of health treatment when physical agents and procedures are the heart of the analysis, e.g. exercises, manipulations, electrical, thermal and surgical treatments, etc. In these cases, the 'blinding' of participants is very difficult, and sometimes quite impossible, for the treatment team to achieve.

In my early years of bio-feedback and pharmaceutical research with my associates and students, I faced these difficulties. We devised complex simulating techniques to mask placebo treatments so that neither the patient nor the assessor of results was aware of what treatment individual patients had received.[1,2,3] At that time, along with others, I began to reject the concept that 'placebos' were entirely inactive agents because a very large proportion of my patients, sometimes with quite serious ailments, were recovering on placebo drugs and other placebo treatments - occasionally up to 50% of the success rate when compared with the patients who had received the investigated drug or therapy. Dissatisfied with the glib designation of these successes with placebos as a 'non-specific effect' to underline our ignorance of such cause-and-effect sequences. In retrospect, I became convinced that my double-blind studies were researches into the power of placebos.[4,5]

Addressing the power of non-specific effects in healing arising from biologic treatments, Alan Roberts with three colleagues[6] analysed the track record of five medical and surgical treatments that once had been considered efficacious, but had later been eliminated by double-blind controlled trials. They did intense analytical studies of laborious uncontrolled outcomes which had been published by the advocates of the five treatments. In summary, their lengthy article showed that for the five medical or sugical treatments that were now obsolete, the combined mean outcome data had been: excellent results 40%; good 30%; poor 30%. They confirmed and upstaged what I had been teaching for a generation or two about the powerful non-specific effects of trust, hope and good faith in the patient/healer partnership.

In discussions and debate with my thoughtful eco-biologist friend, John Vallentyne PhD, I was persuaded that in fact 'non-specific' was no more informative than 'placebo' to describe the sequence, at least in clinical rehabilitation, general medicine and applied psychobiological self-awareness therapies. Why do the placebo therapies in clinical research succeed in significant numbers of patients? In the same vein, why do 'complementary medical treatments', which *prima facie* contain limited and often infinitesimal quantities of active substances, have so wide a following? The conclusion that now seems obvious to me is that the process is driven by the same human internal control mechanisms – mind, body, immune, nervous system and endocrines – that keep us alive and usually healthy. The 'placebo effects' are simply a muted form of the internal responses to the more powerful positive responses obtained by appropriate science-proved therapies. I have coined the term 'debonafide' effects for this self-therapeutic phenomenon:[7] the adjective being derived by joining the three latin words *de*, *bona* and *fide* meaning 'derived from', 'good' and 'faith'. The concept of good-faith healing shared by patient and clinician alike is based on my conviction from the double-blind studies which I carried out - and the many instances in which I have witnessed recoveries where therapies were clearly not present or specific.

RECOMMENDATIONS

The term 'non-specific' is defeatist and should be phased out. The single word 'placebo' should be retained for drug research use, but not 'placebo effect'. Both clinicians and clinical researchers should awaken to – even embrace – debonafide effects in clinical terminology and accept their therapeutic significance in that they account for a great

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number of therapeutic successes in daily medical practice, clinical research, and also in complementary medicine.

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Teacher development in hospital medicine and dentistry

SCOPME (the Standing Committee on Postgraduate Medical and Dental Education) has recently published a follow-up to its 1994 report Teaching Hospital Doctors and Dentists to Teach. This new report, Teacher Development in Hospital Medicine and Dentistry, gives the findings of an enquiry undertaken on the Committee's behalf by Soundings Research and makes recommendations for further work. SCOPME is an advisory body to the Secretary of State for Health on all matters relating to postgraduate and continuing education for doctors and dentists in England.

It is clear that many hospital doctors and dentists are now developing their educational roles, usually through short courses, by acquiring the skills needed for appraisal and assessment, educational supervision, and formal and in-service teaching. This finding is very encouraging.

Given the challenges of specialist training and the proposals to improve the PRHO year and SHO training, SCOPME concludes that it remains imperative that education and service delivery continue to be complementary core activities of the NHS, that the learning opportunities provided by the clinical work are fully utilised and that the time allotted to education is used well. These can only be achieved if hospital doctors and dentists are skilled in their educational roles. The Soundings Research enquiry was undertaken in three stages between July and December 1997. All deaneries are making progress in the areas identified in the 1994 report, some more quickly than others. The targets set by SCOPME in 1994 have yet to be achieved.

SCOPME recommends that the key groups (postgraduate deans, clinical tutors and the medical royal colleges) consider whether there should be systematic data collection on the development of educational roles by hospital doctors and dentists and how this should be done.
The Committee further recommends that:

- the key groups should take action to achieve a coherent national or regional approach to educational role development,
- formal courses on role development should be explicit about their content,
- provision should be made in NHS trusts to support these activities,
- the development of educational roles should be included in continuing education and specialist training,
- there should be in-built evaluations of all educational role development programmes including the views of consultants, doctors and dentists in training and patients.