From the Editor

Clin Med JRCPL
2003;3:397–8

The placebo effect

The placebo effect is a useful but fickle boon to clinical practice.[1]

The good clinical consultation should always leave a patient with an increase in self-esteem and perhaps some alleviation of symptoms as well. Our forebears knew that their clinical skill in the consultation was paramount, given that their medications were often ineffective and functioned solely as placebos. The skilful consultation itself often has a placebo effect depending on the bedside manner needed to boost expectation, while patients' confidence is enhanced by careful explanation: 'The expert doctor is an explaining doctor',[1] and he or she must therefore be trusted.

Relief of symptoms results from altered perceptions, or from physiological changes induced by effective medication, or from the evolution of the disease itself, or sometimes in response to the use of a placebo. In his perceptive article on the use of the placebo in the last issue, Professor Hyland described the measurable physiological changes that result from the use of some placebos.[1] Thus bronchial relaxation in asthma, or improvement in parkinsonian symptoms may follow dopamine release, while pain can be modified by endorphin release. Blood pressure, cardiovascular reactivity, cortisol secretion and immune function may all improve following a strongly supportive clinical consultation.

The effect or lack of effect of a placebo often needs to be gauged against the likelihood of spontaneous recovery. Understanding the natural history of diseases is thus a key component of a successful consultation. JA Ryle, in his famous essay 'The physician as naturalist', emphasised the need not only to understand the progression and often spontaneous resolution of disease but also the 'natural history of man in disease'.[2] It was Sir James MacKenzie who described the family doctor as the one 'who alone saw disease in its true perspective as he had the advantage of observing early symptoms and following an illness from beginning to end'.[3] So unwise physicians, quacks and unperceptive patients might in some situations erroneously attribute their recovery to the effect of placebo medication. Few placebos, if any, can actually modify the pathology of the disease.

The effectiveness of placebo treatment is greatest when there is pain, or a psychological component in the illness in cases of affective disorders, or in those with personality disorders.[1] The amelioration of symptoms in diabetic patients plagued by neuropathic pain is, for example, striking once recovery is promised.[4] The need for and benefits from liaision psychiatry have already been highlighted in an important report from this College, *The psychological care of medical patients*, emphasising the specific support required by many with serious medical conditions as well by those with medically unexplained symptoms.[5]

The use of placebo medications in clinical practice remains controversial. It is an essential ingredient of many placebo controlled trials whose ethics are discussed in detail by Dr John Saunders in this issue[6] and from which placebo effectiveness is often quantified. Their use for patient treatment is controversial, no doubt because the deception required leads to loss of trust, making their use in practice unethical.[7] Yet their undoubted effectiveness in the treatment of some disorders, along with their obvious safety and lack of side effects, makes them in some ways an ideal form of treatment.

Perhaps our forebears had a point after all.

References

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4 Archer AG, Watkins PJ, Thomas PK, Sharma AK, Payan J. The natural history of acute neuropathy in diabetes mellitus. *J Neurol Neurosurg Psychiat* 1983;**46**:491–9.
5 Royal College of Physicians and Royal College of Psychiatrists. *The psychological care of medical patients: a practical guide*, 2nd edn. Report of a working party. London: RCP, 2003.
6 Saunders J, Wainwright P. Risk, Helsinki 2000 and the use of placebo in medical research. *Clin Med* 2003;**3**:435–9.
7 Hill J. Placebos in clinical care: for whose pleasure? *Lancet* 2003;**362**: 254.

Professional standards during epidemics: the Singapore experience

During the plague of 1625, so many Fellows of this College left London that no full meetings could be held, although we are told that William Harvey was not one of the deserters.[1] In another epidemic (1629–30), it was only after financial inducements that Fellows were persuaded to treat plague victims.[1] Many fashionable physicians left town during the great plague of 1665, claiming that they had a duty to follow their patients.[2]

More recently, the behaviour of the medical profession in times of plague has been quite different, but the cost has been high. The moving account of SARS from Singapore in this issue observes that nearly half the cases of SARS occurred amongst health workers, associated with a mortality of 6%.[3] The authors described the spread of SARS from two individual patients to a total of 77 other people, including 26 health workers. Their strenuous efforts to protect health workers were achieved by trial and error, but obviously came too late to save many. Our sympathy goes to those health workers who lost their lives while maintaining the highest standards of commitment to their patients.

References

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2 Porter R. *The greatest benefit to mankind*. London: Harper Collins Publishers, 1997:235.
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Dr A Stuart Mason, 1919–2003

Dr Stuart Mason, a distinguished endocrinologist at the Royal London Hospital, was the founding editor of the *Journal of the Royal College of Physicians of London*. He had been commissioned by the President at the time, Sir Max Rosenheim, to establish a journal which commenced publication towards the end of 1966. Stuart Mason had a clear vision of his intentions: the Journal, he wrote, should be 'a commentary on the whole medical scene, and dedicated to plain speaking, because inflation has debased the printed word and jargon has alienated the inquiring reader.' He observed that the 18th century physician was delighted by the tempo of scientific observation, and that in the 20th century 'his modern counterpart is more likely to be stunned by the profusion of recorded fact and phenomenon'. He persevered as editor for 21 years and set high standards, acknowledged by his successor Dr Robert Mahler who wrote in 1987 that he had been 'an editor with a clear view ... who wrote with a stylish pen'.

Stuart Mason died on 25 August 2003, aged 83 years. We salute his achievements and hope that the high standards he established in 1966 are continuing in *Clinical Medicine*, the successor to the Journal he established 37 years ago.

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