Deceptive Use of Placebos in the Assessment and Management of Pain

Issue Addressed

Deceptive use of placebos by any method to assess or treat an individual's pain regardless of their age, diagnosis, personal characteristics, values or beliefs is contrary to the mission and core values of the American Society for Pain Management Nursing (ASPMN).

Background of Issue

This position statement originated because nurses have been ordered to administer a placebo to discredit a patient's report of pain, or when a patient requests an opioid that professionals believe is unnecessary (Arnstein et al., 2011; Fässler et al., 2010; Ünver et al., 2013). The possible retribution for not carrying out the placebo order can result in moral distress that diminishes the nurses' sense of autonomy, authority, and professional duty to alleviate pain and the ensuing suffering (ANA, 2018).

A placebo is a substance or procedure which is not expected to have any therapeutic benefit (Benedetti, 2014). It is sometimes used clinically to discredit a person's report of pain or deny them available treatments when administered without patient knowledge and consent. This deceptive use of placebos is not to be confused with placebos used in research studies with informed consent of the participants. Further, deceptive use of placebos should not be confused with the *Placebo Effect* which is a desirable therapeutic effect from a non-therapeutic substance or treatment that occurs from activation of endogenous opioids, dopamine, endocannabinoids, adaptive coping, and/or social learning systems. In contrast, a *Nocebo Effect* can occur from a

non-therapeutic substance producing discomfort and therapeutic failures resulting from the recipient's beliefs about potential treatment-related harm. Deceptive clinical encounters in addition to ethical concerns can trigger nocebo activation of cholecystokinin and hypothalamic-pituitary-adrenal systems that heighten sensitivity to pain and anxiety, contributing to maladaptive structural changes in the brain while deactivating endogenous opioid and dopamine systems.

Nurses have a duty to assess and manage pain in an evidence-based and safe way because unrelieved pain can produce serious harm (American Nurses Association [ANA], 2018; ANA, 2015; Macfarlane et al., 2017). Further, the ethical principles of beneficence (duty to benefit another) and nonmaleficence (to do no harm) oblige the nurse to provide interventions with known therapeutic value to relieve pain.

Although pain has been inappropriately assessed and improperly treated with placebos in the past, there is emerging research exploring therapeutic possibilities of placebos for chronic pain when administered in a non-deceptive, open-label approach that includes informed patient consent (Blease et al., Evers et al., 2018; Kaptchuk et al., 2020). This research indicates that while a positive placebo effect in acute pain may be due to cognitive expectations of analgesia, the chronic pain response to placebos is distinctly different. This is largely due to the phenomenon of central sensitization in chronic pain which amplifies and often misinterprets incoming sensory signals to the central nervous system (Darnall & Colloca, 2018). The review by Kaptchuk et al (2020) theorizes that the use of an open- label placebo inserted into a prescribed analgesic regimen for patients with chronic pain, may interrupt the changes seen in the brain of these patients that amplify pain signals. Theoretically, by interjecting uncertainty, the brain's unconscious predictions of how intense pain will be is disrupted. While harnessing the potential power of placebo to treat chronic pain may be appealing, more research is needed

before this option can be ethically and effectively implemented. Advocacy for further placebo research must always embrace clear ethical standards against the deceptive use of placebos and address the potential misunderstandings and misapplication of research findings. This thoughtful approach to placebo research is critical in the current context of increasing fear and reactivity among some healthcare professionals regarding the use of opioids resulting in some patients with pain being abandoned or subjected to forced tapering of opioids in recent years (Arnstein et al., 2011; U.S. Department of Health and Human Services, 2019).

Position Statement

ASPMN opposes the deceptive use of placebos and compels nurses to refuse to administer them. Outside of approved research studies, using placebos to assess or treat pain, constitutes substandard care – and the deceptive use of placebos constitutes fraud. Institutions are advised to establish policies that prohibit placebo use to assess or manage an individual's pain regardless of their race, gender, age, diagnosis, or other factors known to implicitly bias care.

Placebos for pain management may be appropriately administered to participants enrolled in an Institutional Review Board (or equivalent)-approved, blinded clinical trial after being clearly informed they *may* receive a placebo. Those obtaining written consent for an open label trial should clearly inform participants they *will* receive a placebo in the course of the study. All research must be conducted with strict ethical standards to eliminate the deceptive use of placebos to discredit a patient's report of pain. Particular attention should focus on this standard in research investigating the benefits and harms of treating chronic pain with placebos. These informed consent procedures should clearly differentiate placebo from the placebo effect in a non-deceptive way.

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