When Rebecca Ferrini, MD, MPH, CMD, set out to develop AMDA – The Society for Post-Acute and Long-Term Care Medicine’s tool kit The Younger Adult in the Long-Term Care Setting (https://bit.ly/3tS7hUM) almost 10 years ago, she and her coauthors found no research to guide them. “We put out all our questions, all our problems, and we talked through our solutions. We actually had many of the same solutions,” said Dr. Ferrini, the full-time medical director of the County of San Diego’s Edgemoor skilled nursing facility, which serves a largely younger population.

Such is the case today: little if any evidence-based guidance exists on the care of younger residents in nursing homes. However, there is a continually growing collective experience with meeting their social, psychological, psychiatric, and basic human needs while continuing to meet the needs of older residents and complying with federal regulations.

With limited evidence-based guidance, providers working with younger adults in long-term care often rely on collective experience.

Institutional Placebo Effect: Tapping Into the Mind-Body Connection for Better Outcomes

By Travis Neill, PA-C, MMS

I often fantasize about the ideal long-term care facility: a facility without regulations or the resulting need to document everything. In this dream facility — we will call it Nirvana — the nurses, certified nursing assistants, dieticians, therapists, and social workers spend very little time on a computer and more time interacting with the residents. Freed from the burden of documentation, the nurses and certified nursing assistants can do what they do best: provide compassionate care. Of course, because Nirvana is such a wonderful place to work, it is always fully staffed. The staff support each other, and resident conflicts are resolved with forgiveness and accountability. Everyone at Nirvana is an active part of the community, no matter how small, and this leads to a greater sense of purpose and an interconnected sense of family.

The longer I work in long-term care, the more I reimagine Nirvana and how to make it a reality. While the lack of regulations and documentation will stay a fantasy, physicians, physician assistants, and nurse practitioners working
in long-term care can help influence a facility's tone in ways that can yield a more meaningful experience for the staff and better outcomes for the patients. We can do this by teaching facility staff about the power of their influence over the residents’ experience through the ability of the mind-body connection to generate a form of treatment with almost no adverse effects. I call this treatment the “institutional placebo effect.”

The placebo effect is a positive effect produced by a placebo intervention due to the patient’s belief in its effectiveness as opposed to the intervention itself. The power of the placebo lies in the recipient’s expectations and beliefs. The nursing home staff (the institution) have a profound influence on a patient’s expectations and beliefs, whether they are aware of it or not. By understanding and teaching ethical uses of the placebo effect to nursing home staff and residents, providers can dramatically reduce reliance on medications and improve reported symptoms with a limited risk of adverse effects.

When Is Placebo Appropriate?
Imagine you have just taken over care for all the residents at a rural nursing home. Now imagine that most of them are taking opioids for chronic pain and over half are taking either an antidepres-
sant or antipsychotic medication. The residents have learned that if they report pain, anxiety, nausea, poor sleep, or a cough, they will be given medication; the majority are on taking at least 10 medications. The average age of the residents is 85, and about one-third are still “full code.”

I recently faced this reality. Despite my good intentions, the situation was fraught with adverse effects from polypharmacy and an unhealthy dependence on medication to cope with everything. It also posed an interesting challenge: could the concepts of mind-body connection and the power of our influence on the residents’ experience help reduce their dependence on medications and improve their quality of life? The answer was pleasantly surprising.

On the one hand, a placebo is consid-
ered a futile intervention, intended to deceive a patient. The use of placebo has several obvious problems, the most obvi-
ous being that it is illegal and unethical to deceive patients or staff. Opting for placebo instead of a treatment that has been shown effective denudes the patient of the benefit the treatment can provide; also, unlike the real treatment, placebo often has a transient effect.

On the other hand, a large and growing body of evidence has indicated that the placebo effect is associated with symptom relief in many cases regardless of the condition. It can produce substantial symptomatic relief across a wide range of medical conditions. I have discovered that sharing evidence of the placebo effect with facility staff is an effective way to teach them about the power of their influence on patient outcomes.

The Evidence for Placebo
Compelling evidence of the placebo effect was presented as early as the 1950s. A study of patients with angina pectoris used mammary artery ligations. If the surgery bypassed collateral arteries to occur, which was found to have an 80% to 90% success rate in alleviating the symptoms of chest pain (N Engl J Med 1959;261:1017–1020). However, when some of the partic-
ants in the study died years later of other causes, many were found to have no collateral arteries, despite having undergone relief of symptoms. So the surgeons and researchers decided to perform another study whereby they would put people under anesthesia, saw open the breastplate, but not touch any internal structures; they then sewed the patients back up and told them that the mammary artery ligation had occurred. The results were the exact same: 80% to 90% success rate. A couple of years later lawyers pointed out the ethical problems with this study, and the days of using placebo medicine were essentially over.

In 2002 a more ethical approach was taken in a study using arthroscopic surgery for improving pain from osteoarthritis of the knee (N Engl J Med 2002;347:81–88). In this well-designed study the participants were told they would get arthroscopic lavage, arthroscopic debridement, or incisions only (the placebo group). The researchers who assessed the patients for the next two years were blinded to which group the patients were in. The results were that all the participants improved — real surgery had no advantage over placebo at any point during the two years after surgery. Interestingly, with placebos bigger pills are more effective than smaller ones, two pills are more effective than one pill, and pills that elicit some physiological response, like the flushing after taking niacin, are more effective than those that do not. Going beyond pills, procedures like injections with saline are more effective than pills, and the most powerful placebos are surgical. It seems the more ritualistic and intense the placebo, the greater its effect.

Research offers insight into how to reap the benefits of the placebo effect with real surgical interventions. The National Cancer Institute reports that in cancer trials placebos can prove to be effective for symptom relief as much as 20% of the time (J Natl Cancer Inst 2003;95:19-29) whereas leading clinical agents rate at 30%. Based on these results, that means that the physical effectiveness of drugs might only be a marginal 10 percentage points over the mystery of self-healing. Providers who embrace and talk about the placebo effect with patients and staff in nursing homes will find it to be an effective therapeutic tool, consistent with a scientific understanding of the mind-body connection.

Putting Placebo Into Practice
Faced with a culture depen-
dent on medication for vir-

eurally everything, I began an all-staff meeting at the rural nursing home with a presentation on the role of the mind-body connection and the power of the placebo effect. I handed out articles and discussed the studies that have demonstrated the ability of the placebo effect to improve symptoms (N Engl J Med 2011;356:119–126). My focus was on the staff’s ability to improve symptoms through their interactions and relationships with the residents and even with each other.

I suspect most nursing home staff are aware of their influence on a patient’s experience; however, the degree to which they can improve the residents’ symp-
toms by altering the meaning of their illness experience in a positive direction is not well understood and has been significantly underestimated. Through discussion of the science of the placebo effect and offering examples of how their approach and use of language can improve symptoms, the staff began to change the culture from a powerless dependence on medications to an empowered sense they could help patients feel better with less medication.

Shortly after introducing the concept of the placebo effect at the rural nurs-
ing home, I began medication reduc-
tions. One of my main concerns was that reductions in medications for pain, for example, would be met with intense resistance. I discussed how the collective approach the staff took toward a dose reduction could make or break its suc-
cess. The nurses began to change how they would ask if a patient was in pain. For example, a nurse would say, “Now your fentanyl patch has recently been decreased, and I know people who have done much better on lower doses. Are you feeling any better yet, or is it too soon to tell?” This sets the expectation that decreasing the fentanyl dose can generate a positive outcome while still offering them an opportunity to report the response.

We also began to endorse more non-
pharmacological interventions such as ice and heat, and we added topical lido-
caine in place of as-needed hydrocodone. The nurses would mention how effective they thought the lidocaine could be, and they would take some extra time massaging the area where it was applied. We discussed how just the extra atten-
tion, the sense of touch, and voicing an endorsement of the potential ben-
efits could improve the response. The response to this approach, together with as-needed ice or heat, was overwhelm-

ingly positive.

With only a couple of exceptions, the staff and patients at the rural facility embraced the changes and even began asking for faster tapers and broader reduc-
tions. Of course, it wasn’t all smooth sailing, and the staff and residents, as expected, did fail, but most were successful, which I attribute to the staff’s willingness to embrace the idea that their interactions have real power and meaning.

I don’t know if I was more surprised by the response from the residents or the staff, but very quickly it appeared as if the entire facility was embracing the paradigm shift. Instead of resistance, the majority of the staff and residents voiced their approval of less medication. Our next step will be to add a massage therapist and acupuncturist who can offer services to both staff and residents on a weekly basis, once our COVID-19 restrictions allow it.

Environmental Change
The use of a true placebo in a nurs-
ing home is illegal. The main purpose of discussing the placebo effect with staff is to emphasize the power of the mind-body connection. There are some potential placebo-like medications such as vitamin D for pain or St. John’s Wort for depression; however, there is a fine line between exaggerating the potential benefits and conducting an intentional deception. I prefer to emphasize the power of our collective interactions on the patient’s experience. Do they feel people really lis-
ten to them? Is there an environment of trust? Providers who knock on the door before entering a room, sit down instead of stand, get down at residents’ level and keep eye contact, use reflective listening to be sure they understand, and who are truly in the moment without rushing will have better therapeutic outcomes than providers who don’t do these things but make the same clinical decisions. These “emotional intelligence” skills extend to provider interactions with the staff and, in turn, the staff’s interactions with the patient to generate a powerful institu-
tional placebo effect, which can be used to reduce polypharmacy and improve outcomes.

We have enough evidence to encour-
age adoption of placebo techniques and associated responses into clinical prac-
tice. The post-acute and long-term care environment, with its abundance of staff interacting with residents as well as high prevalence of chronic disease, is an ideal environment to emphasize the importance of our interactions on patient outcomes. By introducing and reinforcing the power of the mind-body connection we can tap into this powerful institutional placebo effect to lower costs through less medication with better results. It may not be Nirvana, but it feels like a step in the right direction.

Mr. Neill is a physician assistant who has been working in PALTC for over 10 years.

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Into Practice