Placebo v Nocebo: How to Test Methods of Physician Engagement in Population Health

written by Thomas Dent, M.D. | March 18, 2015

The Holy Grail for value-based health care is to improve patient quality and cost outcomes, while stabilizing or reducing annual aggregate payouts for insurance and government benefits. By holding physicians and health systems accountable, the theory goes, providers will engage with patients in a process leading to better status and lower costs. The key word here is "engage," because none of this happens in a vacuum. Provider engagement is essential for making change happen.

But if engagement is the key, how do physicians' mindsets, attitudes and language play into outcomes? Providers are not a homogenous group, any more than patients can be grouped into a population that will behave exactly the same (no matter how we stratify by age and condition). Scientists have known for some time that placebos are not "neutral" in clinical trials, but independently produce positive effects, healing because of patient belief. Latest evidence is that "nocebos"—suggestions of negative effect—can likewise produce harmful outcomes because of the same power of suggestion.

In a similar way, a provider's positive or negative mindset, attitudes toward the patient or the condition, and choice of words can affect the patient and outcomes. Without evaluating these factors as part of our efforts to improve outcomes, we may miss an essential ingredient that helps patients to improve—or not.

Testing an Appreciative Inquiry Approach in Population Health

"Appreciative Inquiry" is a novel approach used in business to effect positive change. Action research focuses on deliberately making positive or affirmative assumptions, rather than negative ones, to generate ideas for solving a problem. This approach is a distinct departure

from focusing upon penalties, whether financial or reputational, and may have some real benefits for providers and patients to improve population health. But it's never been tested.

We have begun to incorporate some aspects of appreciative inquiry in our ICLOPS population health projects. Note these are "projects," because, at the most basic level, we must find a way to address consumers' common health or clinical problems one by one, and avoid one-shot, expensive solutions to health problems that involve a variety of factors. Here are the basic steps:

> Define a population of patients around one clinical variable. This is the easiest way to start.
> Involve all providers and others involved in the clinical services for these patients. We assume that all are committed to the patients' care, and we need to communicate explicitly the need for their involvement.
> Identify and track a few specific outcomes for the clinical condition.
> Initiate inquiries into the activities or approaches occurring in the practices that appear to "best" manage the outcomes; these should be broadly shared via technology or other means.
> Ask the group what must be done to achieve the dream of optimal care of patients with the condition.

This process of looking for the positive and encouraging its dissemination is the equivalent of the "placebo effect."

Determining the "Nocebo Effect" on Physician Engagement

In order to determine if there is a "nocebo effect" in how physicians are engaged, we might also subsequently identify a separate set of patients with the same condition and ask their physicians to explain why patients are experiencing poor outcomes for the condition. If the patient is admitted to the hospital, seek provider explanations for an admission. This is a typical performance measurement approach that might introduce a nocebo into the provider environment, putting providers on the defensive for doing something "wrong" if their patients don't have good outcomes.

The two approaches, placebo and nocebo, can then be evaluated to determine how outcomes changed (if at all) with each approach. Of course there are many variables that can influence outcomes, but it will be important to begin isolating how our work with providers will affect their efforts with patients. If we collaborate with providers in research to determine better outcomes, will the effect on patients be different than if we treat providers as feckless physicians always in need of monitoring and correction? Shouldn't we begin to think about this?

Forays into population health often assume a cause and effect relationship where none exists, or a linear path to better health status. But the process is much more complex. We need to try many approaches to improve outcomes. Even if we have an approach that seems so intuitively right (or has worked in different settings), it should be studied. We all want—and need—evidence that our actions have done good for patients.

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