

*Letter*

*Questioning the consensus on placebo and nocebo effects*

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## 1 **Text**

2 We read with interest a recent article in this journal reporting the consensus of 27 experts on what  
3 should be communicated to patients about placebo and nocebo effects and how clinicians should be  
4 trained to deliver this information.<sup>1</sup> The authors propose that communicating general information to  
5 patients about placebo and nocebo effects is beneficial but should be adjusted to context. They  
6 further propose that training clinicians to communicate about placebo and nocebo effects should be  
7 a regular and integrated part of medical education. These recommendations build on an earlier  
8 consensus statement regarding maximizing placebo effects and minimizing nocebo effects in clinical  
9 practice.<sup>2</sup> In response, we argue that the latest consensus statement is conceptually ambiguous and  
10 does not accord with recent research on the views of patients and clinicians. Furthermore, the  
11 presentation of these consensus statements belies lively debates and disagreements in placebo  
12 studies research, including on fundamental issues such as the dominance of cognitivist accounts of  
13 placebo and nocebo effects.<sup>3,4</sup>

14 As the authors note, their method did not allow them to draw conclusions about specific  
15 strategies that can maximize placebo effects and minimize nocebo effects. This is, of course, because  
16 ‘placebo’ and ‘nocebo’ are merely umbrella terms that, although useful for coordinating research,  
17 encompass a diverse array of situation-dependent practices too numerous to mention; practices that  
18 patients and clinicians engage in and talk about without need for the abstract umbrella terms. As a  
19 previous editorial position of this journal on the clinical inadequacy of the placebo model suggests<sup>5</sup>,  
20 the attempt to offer general guidelines and training on placebo and nocebo effects risks obscuring  
21 what can be better communicated more precisely.<sup>6,7</sup>

22 Conceptual concerns notwithstanding, recommending that tailored, evidence-based  
23 explanations of placebo and nocebo effects should be explained to patients – and that the terms  
24 themselves are acceptable – is at odds with recent systematic reviews of the use and understanding  
25 of clinical placebo effects. For example, one qualitative synthesis of 28 studies in primary care  
26 concluded that there is so much disconnect between modern scientific definitions of placebo effects  
27 and how patients and clinicians understand them, that attempts to bridge this gap are unlikely to  
28 succeed.<sup>8</sup> This not only undermines potential communication and training strategies, but also  
29 questions existing prevalence of use data and broader empirical findings on placebo effects in clinical  
30 practice.<sup>8,9</sup> Moreover, although the recommendation for guidelines and training in communicating  
31 about placebo and nocebo effects is well-intentioned, given the unmanageable number of existing  
32 guidelines in modern evidence-based medicine<sup>10</sup>, it is unlikely that clinicians will have time to  
33 meaningfully engage. What should clinicians tell patients about placebo and nocebo effects? In most

34 cases probably nothing. In most cases – except certain specific scenarios – there are likely less  
35 confusing and contentious ways in which to talk about phenomena the umbrella terms purport to  
36 encompass.

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38 **Statements**

39 **Conflict of Interest Statement**

40 The authors have no conflicts of interest to declare.

41 **Author Contributions**

42 **Doug Hardman:** Conceptualization; Formal analysis; Writing - original draft.

43 **Phil Hutchinson:** Conceptualization; Formal analysis; Writing - review & editing.

44 **Giulio Ongaro:** Conceptualization; Formal analysis; Writing - review & editing.

## References

1. Evers AWM, Colloca L, Blease C, et al. What Should Clinicians Tell Patients about Placebo and Nocebo Effects? Practical Considerations Based on Expert Consensus. *Psychotherapy and Psychosomatics* 2020.
2. Evers AWM, Colloca L, Blease C, et al. Implications of Placebo and Nocebo Effects for Clinical Practice: Expert Consensus. *Psychotherapy and Psychosomatics* 2018; 1-7.
3. Thompson JJ, Ritenbaugh C, Nichter M. Reconsidering the placebo response from a broad anthropological perspective. *Culture, Medicine, and Psychiatry* 2009; **33**(1): 112-52.
4. Hutchinson P. The “placebo” paradox and the emotion paradox: Challenges to psychological explanation. *Theory & Psychology* 2020; **30**(5): 617-37.
5. Fava GA, Guidi J, Rafanelli C, Rickels K. The Clinical Inadequacy of the Placebo Model and the Development of an Alternative Conceptual Framework. *Psychotherapy and Psychosomatics* 2017; **86**(6): 332-40.
6. Turner A. ‘Placebos’ and the logic of placebo comparison. *Biology & Philosophy* 2012; **27**(3): 419-32.
7. Moerman DE. Chapter 18 - Against ‘Placebo.’ The Case for Changing our Language, and for the Meaning Response. In: Colloca L, Flaten MA, Meissner K, eds. *Placebo and Pain*. San Diego: Academic Press; 2013: 183-8.
8. Hardman D, Geraghty AWA, Lewith G, Lown M, Viecelli C, Bishop FL. From substance to process: A meta-ethnographic review of how healthcare professionals and patients understand placebos and their effects in primary care. *Health* 2018; **24**(3): 315-40.
9. Linde K, Atmann O, Meissner K, et al. How often do general practitioners use placebos and non-specific interventions? Systematic review and meta-analysis of surveys. *PLoS One* 2018; **13**(8): e0202211.
10. Greenhalgh T, Howick J, Maskrey N. Evidence based medicine: a movement in crisis? *BMJ* 2014; **348**: g3725.