Questioning the Consensus on Placebo and Nocebo Effects

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

As the authors note, their method did not allow them to draw conclusions about specific strategies that can maximize placebo effects and minimize nocebo effects. This is, of course, because "placebo" and "nocebo" are merely umbrella terms that, though useful for coordinating research, encompass a diverse array of situation-dependent practices too numerous to mention – practices that patients and clinicians engage in and talk about without the need for abstract umbrella terms. As a previous editorial position of *Psychotherapy and Psychosomatics* on the clinical inadequacy of the placebo model suggests [5], the attempt to offer general guidelines and training on placebo and nocebo effects risks obscuring what can be better communicated more precisely [6, 7].

Conceptual concerns notwithstanding, recommending that tailored, evidence-based explanations of placebo and nocebo effects should be explained to patients – and that the terms themselves are acceptable – is at odds with recent systematic reviews of the use and understanding of clinical placebo effects. For example, one qualitative synthesis of 28 studies in primary care concluded that there is so much disconnect between modern scientific definitions of placebo effects and how patients and clinicians understand them, that attempts to bridge this gap are unlikely to succeed [8]. This not only undermines potential communication and training strategies but also questions the existing prevalence of use data and broader empirical

findings on placebo effects in clinical practice [8, 9]. Moreover, although the recommendation for guidelines and training in communicating about placebo and nocebo effects is well intentioned, given the unmanageable number of existing guidelines in modern evidence-based medicine [10], it is unlikely that clinicians will have time to meaningfully engage. What should clinicians tell patients about placebo and nocebo effects? In most cases probably nothing. In most cases – except certain specific scenarios – there are likely less confusing and contentious ways in which to talk about phenomena the umbrella terms purport to encompass.

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Author Contributions

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