

<http://somatosphere.net/2008/10/prevalent-placebo.html>

The prevalent placebo

2008-10-27 16:12:00

By Eugene Raikhel

One of the main stories in health research last week concerned the results of a [survey, published in BMJ](#), according to which around 50% of US physicians regularly prescribe “placebo treatments.” The survey was carried out by a team including researchers at the University of Chicago, the NIH’s Department of Bioethics and Harvard Medical School. One of the authors, [Ted Kaptchuk](#), is one of the leading researchers of placebo phenomena (as well as [Chinese medicine](#)), who has carried out some of the most interesting work—both experimental and historical—on the topic.

The story was heavily reported in the media – there was a prominent [NY Times article](#) describing it – and much-discussed in the medical blogosphere. Most of that discussion has focused on the ethical question of whether or not this kind of “placebo treatment” should be practiced, and if so, under what conditions. I want to discuss a couple of points which are related, but address slightly different questions.

First, the basic findings, as described in the paper’s abstract:

679 physicians (57%) responded to the survey. About half of the surveyed internists and rheumatologists reported prescribing placebo treatments on a regular basis (46-58%, depending on how the question was phrased). Most physicians (399, 62%) believed the practice to be ethically permissible. Few reported using saline (18, 3%) or sugar pills (12, 2%) as placebo treatments, while large proportions reported using over the counter analgesics (267, 41%) and vitamins (243, 38%) as placebo treatments within the past year. A small but notable proportion of physicians reported using antibiotics (86, 13%) and sedatives (86, 13%) as placebo treatments during the same period. Furthermore, physicians who use placebo treatments most commonly describe them to patients as a potentially beneficial medicine or treatment not typically used for their condition (241, 68%); only rarely do they explicitly describe them as placebos (18, 5%), ([Tilburt et al. 2008: 1](#)).

As the authors point out, while the high prevalence of “placebo therapy”

may seem striking, previous surveys have had similar results. Most recently, in a [study](#) carried out by Rachel Sherman and John Hickner of the University of Chicago, 45% of academic physicians surveyed reported having used a placebo in their clinical practice.

Some of the blog discussion on this article has concerned the issue of what the authors called these treatments in their survey—that is, did they use the term “placebo” or not? This points to one of the central problems of much research on placebo phenomena. The authors acknowledge the difficulty of defining “placebo treatment” in contemporary clinical medicine:

“Placebo treatment” is an unclear and complicated concept that lacks a standard definition. Placebo treatments include “inert” agents that have little or no pharmacological activity, such as sugar pills and saline injections given to promote positive expectation, and physiologically active agents, such as vitamins or antibiotics, that the physician prescribes solely or primarily to promote positive psychological effects. Furthermore, clinicians might recommend an “active” treatment to elicit a possible pharmacological effect and a placebo response simultaneously. Given these and other terminological difficulties, for the purposes of our research we defined a “placebo treatment” as a treatment whose benefits (in the opinion of the clinician) derive from positive patient expectations and not from the physiological mechanism of the treatment itself ([Tilburt et al. 2008: 1](#)).

I think this is an instance when it’s particularly useful to apply the basic anthropological distinction between the categories used by social actors in their daily practice (in this case internists and rheumatologists) and the categories we use to analyze them. While the authors of this paper have chosen to use “placebo” as their analytical category, it is a difficult and often confusing one—in part because of the ways that the term “placebo” has been used in the past. A number of authors – most notably [Anne Harrington](#) – have pointed out that “placebo effect” has generally been used to refer to:

- (a) a short-term and illusory impression of improved health that some patients experience when they take an inert substance that looks like real medicine (e.g. a sugar pill);
- (b) the non-specific effects of medical treatment that, in clinical trials, must be controlled in order for researchers to assess the specific effects of new interventions, especially drugs;

(c) a powerful mind–body phenomenon with a specific ‘real’ biology all its own, one that medicine should study and exploit ([Harrington 2006: 181](#)).

While something like the third usage is the one used in studies such as this one, the first two meanings—“placebo as sham” and “placebo as noise in the data”—are arguably the most common; they certainly frame the way in which “placebo” is understood in most non-medical contexts.

Another problem is that the term also focuses our attention on the medication or substance, rather than on the meanings ascribed to that substance by the patient, or to the general context of the physician-patient encounter. Moreover, [as is generally acknowledged in the literature](#), you do not need “a placebo” for the “placebo effect” to take place. In fact, the effects of a physiologically-active medication is also partly due to non-specific effects. This can be demonstrated in experiments which use hidden administration: one group of participants receives a medication and is aware that they are receiving it, while another receives the same medication without being told that they are receiving it. (This kind of study obviously has to be designed carefully in order to deal with the ethical problems of hidden administration). [Studies using this paradigm](#) have shown, for example, that patients receiving an analgesic experience a greater relief of pain when they are aware of the treatment than when they are not.

Alternative terms have been suggested, and they highlight these broader aspects of the phenomenon: [Daniel Moerman](#)’s notion of the “[meaning response](#),” and the idea of “[contextual healing](#)” recently proposed by Kaptchuk and [Franklin Miller](#) – another author of the current study as well.

Given this confusion and often negative connotations, it isn’t so surprising that the authors chose not to use the term in their survey:

Because the term “placebo” and behaviours surrounding its use can be contentious, we devised a series of non-judgmental questions beginning with broad questions that avoided the term “placebo” and then gradually gained more specificity, culminating in items whose responses used a clear definition of a “placebo treatment,” ([Tilburt et al. 2008: 2](#))

This is an interesting issue in itself: it seems that physicians are unlikely to refer to their practices as “placebo therapy,” even if they fit into the definition given for such therapy by these researchers. Is this because

they fear discrediting their therapies by labeling them this way (even in encounters with non-patients) or because “placebo therapy” requires a [misrecognition](#) on the part of physicians (as well as patients) in order to work?

While the public discussion on this study moves directly to the ethical questions, I actually think that—like many surveys—this one raises a number of additional questions (many of which the authors themselves bring up in their discussion).

First of all, it would be useful to know more about whether the prevalence of “placebo therapy”—as the authors define it—differs from one medical specialty to another. I would also want to know about the characteristics of the patients who generally receive such therapy; they may be the “difficult” ones, but are there any links to gender, class, ethnicity, education level, etc.? In other words, is this “placebo therapy” another means through which existing dimensions of inequality become amplified in the clinical encounter?

There are also questions which—I would argue—can only be adequately addressed through some ethnographic or other in-depth qualitative research. How do physicians conceptualize their giving of such therapies? How do they think through the risks and benefits of such therapies—if indeed they even think about them in such terms? How do they conceptualize the efficacy of such treatments? Do they see themselves as beneficent professionals or are they struggling to reconcile these practices with the reigning ideas of patient autonomy? Why do so few physicians prescribe “inert” substances such as saline? Does prescribing substances which have some clear physiological effect—even if not one pertaining to the illness in question—help physicians to manage the ethical quandaries of deceiving their patients? What do these encounters actually look like? What do physicians tell patients, and what do patients understand them to say? And finally, what kinds of broader public or professional discourses are physicians and patients drawing upon for their ideas about “placebos” or about other ways in which “mind” can influence “body” in healing?

In any case, I think that there is a lot which medical anthropology can contribute to these discussions, both through new ethnographic work and through the synthesis of work which has already been conducted under different rubrics such as [embodiment](#), [somatization](#) and psychologization, [local biologies](#), and others.

Tilburt, J.C., Emanuel, E.J., Kaptchuk, T.J., Curlin, F.A. & Miller, F.G., 2008, [Prescribing “placebo treatments”: results of national survey of US internists and rheumatologists](#), *BMJ (Clinical research ed.)*, 337, p. a1938.

Harrington, A., 2006, [The Many Meanings of the Placebo Effect: Where They Came From, Why They Matter](#), *BioSocieties*, 1(02), pp. 181-93.

Similar Posts

- [Psychoanalytic metaphors and mythical medical realities in Claude Lévi-Strauss's contribution to medical anthropology](#)
- [Give me the fear!](#)
- [Grandma's little helper](#)
- [Critical neuroscience and anthropological engagement](#)
- [A medical anthropology blog...](#)

AMA citation

Raikhel E. The prevalent placebo. *Somatosphere*. 2008. Available at: <http://somatosphere.net/2008/10/prevalent-placebo.html>. Accessed October 7, 2011.

APA citation

Raikhel, Eugene. (2008). *The prevalent placebo*. Retrieved October 7, 2011, from Somatosphere Web site: <http://somatosphere.net/2008/10/prevalent-placebo.html>

Chicago citation

Raikhel, Eugene. 2008. The prevalent placebo. *Somatosphere*. <http://somatosphere.net/2008/10/prevalent-placebo.html> (accessed October 7, 2011).

Harvard citation

Raikhel, E 2008, *The prevalent placebo*, *Somatosphere*. Retrieved October 7, 2011, from <http://somatosphere.net/2008/10/prevalent-placebo.html>

MLA citation

Raikhel, Eugene. "The prevalent placebo." 27 Oct. 2008. *Somatosphere*. Accessed 7 Oct. 2011. <http://somatosphere.net/2008/10/prevalent-placebo.html>