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Manufacturing the placebo effect

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Abstract

In the context of modern medicine, the placebo effect is a troublesome and controversial phrase. In this paper, I use investigative ordinary language philosophy to try to get clear on what it means. In so doing, I uncover three points. (i) The placebo effect makes sense in research but not clinical practice. (ii) To make the phrase make sense in clinical practice, we must manufacture a situation in which we can change linguistic habits. (iii) Such action is not necessary because in clinical practice we do better with other, more settled words and phrases.

I. Introduction

In the context of modern medicine, the placebo effect is a troublesome and controversial phrase. I am here trying to get clear on what it means. I take the process of getting clear to be a mundane matter, which involves constructing detailed and convincing examples of everyday situations in which the phrase realistically occurs, and reflecting on the circumstances that might make claims about it intelligible.[1] John Cook termed this approach *investigative ordinary language philosophy*, highlighting Frank Ebersole as its main architect.[2] Don Levi subsequently more accurately characterised such an Ebersolean approach as being faithful not to ordinary language but human situations; specifically, what people do, say, and mean in those situations.[3] Given the longstanding philosophical problems with the placebo effect, I hope that the underused approach of Ebersolean investigative ordinary language philosophy may help to dissolve some issues that currently lead placebo studies researchers astray.

There are many definitions of the placebo effect; yet, none is universally accepted. It can be conceived either narrowly as the 'psychological' effect

1. Ebersole (1956, 2002a, 2002b, 2001).
2. Cook (2000).
3. Levi (2004).

of a drug or treatment, or widely as an inherent part of all treatment.[4] Such ambiguity notwithstanding, the placebo effect is of medical interest for two reasons. First, methodologically, to better understand the conduct of a Randomised Controlled Trial (RCT). Second, clinically, to understand how clinicians might harness it in clinical practice. Although these reasons can be considered individually, they are interrelated inasmuch as the modern notion of the clinical placebo effect is grounded in how we validate the existence of therapeutic effects.[5] The notion of the 'placebo pill' as a substance used in research informs the common lay definition of the placebo effect as the psychological effect of an inert substance.[6] This lay definition raises the essential paradox of the placebo effect: how can something inert ('nothing') have an effect? Modern attempts to make sense of the placebo effect aim to resolve (or avoid) this paradox.[7]

Reflecting the two reasons for medical interest in the placebo effect, there are broadly two kinds of medical situation in which the phenomenon is purportedly important: researchers conducting randomised controlled trials, and clinicians interacting with patients.[8] Although related, I will consider each situation in turn. My process of getting clear will uncover three points. (i) The placebo effect makes sense in research but not clinical practice. (ii) To make the phrase make sense in clinical practice, we must manufacture a situation in which we can change linguistic habits. (iii) Such action is not necessary because in clinical practice we do better with other, more settled words and phrases.

II. The placebo effect in research

(1) Two researchers, Professor Te'o and Dr Jones, are on a call discussing their proposed randomised controlled trial (RCT) related to chronic

4. Hardman *et al.* (2020a).
5. Miller and Brody (2011).
6. Although it should be noted that the term 'placebo' as an inert substance has a longer history (Beecher, 1955; Hardman *et al.* 2020a). The first direct use of the term 'placebo' in a medical context emerged in the late 18th century, where physicians described giving patients very low doses of medicine that in higher doses might have some ostensible drug effect. The notion of a placebo as a diluted substance persisted through the 19th century and was accompanied by a further notion of a placebo as an inert substance, like that derived from the 'placebo pill' in a trial. See Kerr *et al.* (2008) and Jütte (2013).
7. Miller (2018).
8. For the purpose of maintaining a viable scope, I exclude other situations where the use of the placebo effect might differ. For example, in research I exclude the situations in which researchers communicate their results to external parties. In clinical practice, I exclude the situations in which clinicians interact with other clinicians. The usefulness of the placebo effect may well be different in those situations and raises the issue that there are multiple audiences for talk about the placebo effect, all of which are not covered here.

kidney disease (CKD). Dr Jones raises a concern that their current design does not effectively control for the placebo effect, and sparks debate on what they can do to remedy it. In the proposed trial, Professor Te'o and Dr Jones are trying to establish if drugs currently effective in reducing deaths in patients with heart disease – aldosterone receptor antagonists – might have the same effect in patients with CKD. This is plausible, based on existing evidence that the drugs may reduce kidney damage credited to circulating aldosterone. In the trial, patients with CKD are randomised into two groups. One group will receive standard care along with a low dose of spironolactone, an aldosterone receptor antagonist. The other will receive standard care alongside an 'inert' pill designed to look, feel and taste identical to spironolactone. Following the common understanding of a placebo as an inert substance, the placebo effect in this instance is the effect of the pill designed to look, feel and taste identical to spironolactone. This is, of course, paradoxical. If the pill designed to look, feel and taste identical to spironolactone is inert, it cannot cause an effect.[9] So, what does Dr Jones mean when she talks about the 'placebo group', about participants receiving 'placebo' and ensuring that they have 'controlled for the placebo effect'?

In answering this question, we must first consider the epistemic aim of Professor Te'o and Dr Jones's RCT. They are trying to learn about the efficacy of a particular aspect of treatment: that is, the drug effect of spironolactone. To do this, they need to construct two groups that, as best as they can, are identical in all therapeutically relevant aspects but for the aspect under investigation. As is almost too obvious to mention, this process of comparison needs much more than identical pills to succeed. It requires everything else about the treatment – setting, interaction, timings, communication, etc. – to be controlled as far as practically possible. The placebo effect that is controlled for is thus not the effect of an inert substance. The pill in question is not a special object called 'placebo' but merely one aspect that might be required in a specific process of comparison between two groups in a trial. Inasmuch as this is true, Turner argues that we should abandon talk of placebos in research situations, even as a shorthand, because it risks obscuring the specific details of the particular comparison process in question.[10] On this view, in talking about placebos and their effects, Dr Jones risks overlooking key aspects that may determine the success of the crucial comparison process.

9. Although as others have noted, nothing is strictly inert. Even a sugar or bread pill has some physiological effect, which for some people (e.g. a diabetic) might be significant: see Howick (2017).
10. Turner (2012).

As Turner himself notes, in an RCT, the paradoxical semantics of placebo terminology are mute unless they lead to clinically meaningful mistakes.[11] The usefulness of placebo terminology in an RCT is an empirical matter. Supporting his claim, Turner highlights the issue of poor comparison processes unblinding trials, which affects credible findings. Ensuring trials are blind is certainly difficult and remains a significant problem.[12] However, it is unclear how blinding issues are directly related to the use of placebo terminology. When Dr Jones talks about patients taking a placebo, and about controlling for the placebo effect, she does so within the clear methodological confines of the trial. She is aware of the difficulties of creating near identical groups in a trial – she has been grappling with this problem her whole career. When Dr Jones uses placebo terminology, this does not preclude her from talking about specific issues such as the person providing the treatment, what they say to participants, where it is conducted, etc. These are all issues that are discussed and planned for by Dr Jones, Professor Te'o and their team because they know these are issues that can markedly affect the results of the trial. Moreover, developments in trial methodology, including with respect to the credibility of the central comparison process, suggest that researchers increasingly have these issues in mind.[13] For instance, a real example of a trial investigating if aldosterone receptor antagonists reduce death in patients with CKD used a prospective randomised open blinded endpoint (PROBE) design[14] in response to, among other issues, problems with blinding.

The paradox of the placebo effect does not seem terminal within an RCT. Within the framework of the practical actions required to ensure that a trial is successful, placebo terminology might not be problematic. It could be clearer if researchers abandoned placebo terminology, but they seem to be getting along fine. Furthermore, given the ubiquity of placebo terminology in research, it seems fruitless to pursue a clarifying programme. Outside the situation of an RCT, however, it seems more problematic.

III. The placebo effect in clinical practice

(2) Mr Hussain suffers with back pain, which can make even basic tasks difficult and painful. He usually manages this himself but has recently

11. Turner (2012).
12. Deaton and Cartwright (2018).
13. Many related issues are raised from different perspectives. See Howick (2009), Meeker-O'Connell *et al.* (2016), Reith *et al.* (2013) and Tunis *et al.* (2003).
14. Hansson *et al.* (1992).

been struggling and reluctantly books an appointment with his GP, Dr Andrews. The chair in the surgery waiting room is hard. He waits, shuffling uncomfortably. His name is finally called, and he walks gingerly down the long corridor to the consultation room. Dr Andrews is, as she always is, welcoming, positive and confident. After inquiring about his symptoms, she examines him carefully. She assures him that, although undoubtedly painful, the problem should pass in a few weeks. She goes through some exercises he can do to help, and suggests some non-steroidal anti-inflammatory painkillers, although she does not think that they will make much difference. Mr Hussain thanks her and walks (a little less gingerly) out of the consultation room and back down the corridor. For the rest of the day, his back feels a little less painful. In a week, he is moving much as he normally does.

Understood narrowly as the psychological effect of an inert substance, there is no placebo effect in this situation.[15] However, given the paradox inherent to substance-based accounts of the placebo effect – nothing having an effect – researchers have widened the definition of the phenomenon. The clinical placebo effect is now "generally understood as consisting of individuals' responses to the psychosocial context of medical treatments, 'inert' interventions, or clinical encounters, as distinct from the inherent or characteristic physiological effects of medical interventions."[16] On this definition, the placebo effect encompasses *any* beneficial treatment effect that cannot be attributed to the characteristic effect of the treatment in question.[17] A 'placebo pill' is thus merely a symbolic object that is or is not part of a treatment process. In the case of Mr Hussain, we can highlight several non-characteristic factors that could have caused a beneficial treatment effect, including the welcoming, positive and confident manner of Dr Andrews; relief from Dr Andrews' physical examination during the consultation; the increased movement from going to the surgery; Mr Hussain's hope that he will get better; and any interrelated effects of such practices. Widening the definition of the placebo effect to encompass the psychosocial context of treatment avoids the placebo paradox of nothing having an effect. We can now

15. One could say that a non-steroidal anti-inflammatory painkiller Dr Andrews prescribes is an 'impure' placebo substance, referring to drugs or supplements clinicians know or suspect have no characteristic effect on a patient's pathophysiological condition. However, this practice is arguably unethical, lacking transparency and informed consent, see Kaptchuk *et al.* (2020). Moreover, as noted previously, nothing is inert or pure, thus the impure definition seems untenable. In any case, the placebo paradox remains with an impure placebo, insofar as it is still 'nothing' (rather than the drug mechanism) to which the cause is attributed.

16. Miller *et al.* (2013: ix).

17. Grünbaum (1986) and Howick (2017).

talk intelligibly about credible causes, such as the welcoming manner of Dr Andrews or the increased movement from going to the surgery.

However, although widening the definition of the placebo effect in this way avoids the central placebo paradox, it raises another problem: what work is the placebo effect concept now doing?[18] Dr Andrews certainly did not need to think or talk about the placebo effect in her consultation with Mr Hussain. Depending on Mr Hussain's prior conception of the placebo effect, talking about it could even have made the situation more confusing. If he held the most common conception – inert pills having a psychological effect[19] – Dr Andrews would have had to explain what *she* meant by the placebo effect, based on the modern, wider definition. In any case, it would not make sense for her to explain to Mr Hussain that, for example, she was being welcoming and positive; being welcoming and positive is not something that needs explanation. We can surely see that this whole situation is confused. None of the 'non-characteristic' factors in this situation needs explaining in terms of the placebo effect; they are perfectly intelligible on their own terms. However, before coming to a premature conclusion, let us consider some more examples.

(3) Anne is a generally healthy young woman who goes to see her doctor because she has a very sore throat and a runny nose. She does not feel well.

"I'm not trying to do your job here doc, but I think I could really do with some antibiotics, just to nip this in the bud", says Anne.

Why don't we start off from the beginning? Can you tell me how long you have been feeling like this and how it started?" Dr Dowling examines Anne and decides that, although Anne is unwell, she has a cold that is likely to get better by itself. "I think we might be best keeping the antibiotics in reserve for this one. I really think you should get home to rest – put your feet up for once! It's amazing what your body can do for itself if you give it the right support. If you're still feeling bad in a week, come back and see me. The door's always open.

(4) Steve is a recently retired man who lives on his own. He goes to see his doctor because he has had a sore knee for a couple of weeks.

"Can you describe the pain, Steve? How long have you had it for? How do you think it started?", asks Dr Smith. After describing his pain, Steve sits on the bed so Dr Smith can conduct a physical examination. Dr Smith, despite looking closely, does not find anything particularly wrong with the knee. To make sure, he tells Steve that he will order

18. As Nunn (2009b) notes, it also raises another troubling paradox that needs to be overcome: the placebo effect without a placebo.
19. Hardman *et al.* (2020a).

some blood tests and that, when the results are back, Steve should come in to discuss them. He gives Steve a prescription for some painkillers in the meantime.

"Thanks doc. It's just difficult is all. I'm barely making it into town anymore it's so painful. It's a long day on my own up at the cottage." Despite already running late, Dr Smith listens to Steve and suggests some ways he may be able to cope with this. By the time they are finished, Dr Smith is running late and has a number of patients waiting to see him.

(5) Ray is a middle-aged man who has diabetes. He has come to see his doctor for his regular check-up.

We're struggling to control it at the moment, aren't we?" says Dr Wallace looking at the tests results, "Why do you think you're finding it so difficult at the moment?

"I guess I've kind of fallen off the wagon lately. Been busy at work; not exercising as much as I should; too many snacks in the evening", says Ray. Dr Wallace is normally quite laid-back but, in this consultation, she is quite firm with Ray.

"Come on Ray, you know what you've got to do here. You're better than this. You need to take your head out of the sand and get back to doing regular readings every day." After discussing some strategies to get back on track, Ray agrees, and Dr Wallace arranges for a follow-up consultation in a few weeks.

In example (3) it is clear that Dr Dowling does not think Anne has a bacterial infection that would benefit from an antibiotic. Given various reasons, including the risk of antibiotic resistance, Dr Dowling convinces Anne that she does not need antibiotics and that her 'amazing' body can, in this instance, do the healing job all by itself. Dr Dowling's role in invoking the body's inherent healing capacity could be conceived as a placebo effect under a modern, wide definition of the term. But, as in example (2), Dr Dowling does not need to talk to Anne about the placebo effect. In fact, doing so would likely confuse matters again. Anne might be in the minority of patients who equate the placebo effect with self-healing, but she might also be in the majority who equate it with the psychological effects of an inert substance. As in example (2), if the latter were the case, Dr Dowling would then have to explain what she meant by the placebo effect, and how this is relevant to the case at hand. Again, this is obviously not necessary, as there is no confusion to resolve or benefit to be gained by describing the body's self-healing capacity in terms of the placebo effect. This is also the case in example (4). We could, if pushed, describe Dr Smith listening to Steve as part of the placebo effect. But introducing such a clinical term in the midst of an emotional discussion is surely not helpful. Steve seems lonely, and it is on

human, relational terms that the conversation with Dr Smith occurs. In example (5), Dr Wallace is very firm with Ray, who is not looking after himself. She can do this because she has known Ray for a long time and they have built up a trusting relationship. Such a firm approach is not normally considered as an example of the placebo effect, but in this situation we could credibly ascribe a beneficial treatment effect to Dr Wallace's approach if it gets Ray back to taking his daily readings and managing his blood sugar. Thus, by the modern definition, this is part of the placebo effect. As with examples (3) and (4), however, it is difficult to see what could be gained from explaining this situation in terms of the placebo effect or referring to the placebo effect in conversation.

In line with previous empirical and philosophical findings,[20] I suggest that in many clinical situations in which the placebo effect could be invoked we do better without it. Turner's argument that the placebo effect obscures what can be better communicated more precisely – although I argue debatable in research situations – seems correct in the clinic.[21] However, this is not the position taken by many placebo studies researchers. For example, in a recent consensus article, 27 experts advised that general information about placebo and nocebo effects should be communicated to patients, although they did not propose specific strategies.[22] As seems clear from the examples here – and as noted in a response to the consensus article[23] – the experts did not propose specific strategies because 'placebo' and 'nocebo' are merely umbrella terms for a diverse array of practices that are better understood on their own terms.[24] Inasmuch as this is true, this would seem to be the end of the matter for promoting the placebo effect as a communicative or explanatory strategy in clinical practice. We can accept that the placebo effect is a useful shorthand phrase in research, but forget about its use in the clinic. Before concluding, however, there is one specific proposed treatment that did not emerge in the examples, and which does not succumb to the argument that the placebo effect obscures what can be better communicated more precisely.

20. For example: Hardman *et al.* (2020a), Hutchinson and Moerman (2018), Moerman (2002) and Nunn (2009a).
21. Turner (2012) makes this point himself in a footnote, noting that his argument will likely apply in clinical practice although his paper is focused on clinical research.
22. Evers *et al.* (2020).
23. Hardman et al. (2020c).
24. In a more recent article, Turner (2018) discusses the merits of redefining, reconceptualising and eliminating placebo language, noting that although conceptually confusing, it is less clear in what situations placebo language is unhelpful. This article is in part an exploration of such situations.

IV. Manufacturing the placebo effect

(6) Michael has been living with Irritable Bowel Syndrome (IBS), a chronic functional gastrointestinal disorder, for some years. The symptoms, such as abdominal pain and uncomfortable bowel movements, significantly affect his quality of life. Although he has tried many different therapies, like many others who suffer with IBS he has not found one that helps. One day, while flicking through the local paper, he spots an advertisement for a novel mind-body management study of IBS. Given that nothing else has worked, he decides to give it a go. He calls the number at the bottom of the advertisement and is given a time when they will call him back. After answering a few questions about his health, he is told that during the study participants would receive either placebo (inert) pills, like sugar pills, which have been shown to have self-healing properties, or no treatment. Michael is intrigued but does not really know what to make of it. He is eventually accepted onto the study and attends a meeting with a nurse-practitioner at his local medical centre. He is asked if he has ever heard of the placebo effect and then given a reasonably long explanation of it. The nurse-practitioner covers four discussion points: the placebo effect is powerful; the body can automatically respond to taking placebo pills; a positive attitude can help but is not essential; and that he must take the pills exactly as instructed during the study. After completing a physical examination, Michael is then told that he has been allocated to the group that will be given the placebo pills. He is given a medical- looking pill bottle with a label marked "placebo pills, take 2 pills twice daily." Over the course of three weeks, he takes the blue and maroon pills as instructed. This is augmented by a visit halfway through, in which a warm and supportive clinician asks him some questions about how he is doing and conducts a brief physical examination. When he was first told what the study entailed, Michael was sceptical. However, in talking with the clinicians throughout the study he becomes more positive about the treatment. At the end of the three weeks there is no doubt in his mind: he feels better. His abdominal pain has noticeably improved and he just all round feels happier. Even though he was told that he was taking a placebo, it seemed to work anyway.

This example is based on the procedure of a randomised controlled trial in IBS, testing whether non-deceptive and non-concealed administration of placebo pills – termed 'open label placebo' (OLP) treatment – is better than no treatment.[25] Although the trial was small, with only 80 participants, the results reflected Michael's experience. OLP produced

25. Kaptchuk *et al.* (2010).

significantly higher scores in the IBS Global Improvement Scale and reduced symptom severity. Other trials of OLP – albeit similarly small – have been conducted in other conditions, including chronic back pain[26] and episodic migraine,[27] with similarly positive results. Given the lack of effective treatments in conditions such as IBS or chronic back pain, OLP is increasingly promoted as a bold new treatment. Its success also seems to contradict my argument that clinicians should not talk about the placebo effect in the clinic. However, although it would be good if an effective general treatment could be found for difficult-to-treat chronic conditions, I argue that translating the results from these small trials into a clinically meaningful practice is not straightforward.

First, extant OLP trials are small, which, as even those who conduct such trials admit, means that we do not know if the results will be replicated in larger trials conducted over a longer duration.[28] Second, the way in which beneficial treatment effects are invoked in OLP trials raises a more terminal issue. Researchers promoting OLP are aware of the placebo paradox. As such, they do not ascribe the cause of beneficial treatment effects to the placebo pill itself; if Michael merely walked into an empty room and took a sugar pill without any instruction or context, we might reasonably not expect any beneficial effects. The pill acts as a central symbolic object in OLP treatment but is not effective on its own. Instead, the cause of such an effect is broadly posited as the psychosocial context of treatment, in line with a modern definition of the placebo effect. But, as we see in example (6) – which is based on a real trial in IBS – a huge amount of work is required to create the particular psychosocial context of treatment in an OLP trial. Michael first encounters the potential treatment defined as novel mind-body management, before being told placebo pills have self-healing properties. He then attends an academic medical centre for a briefing and assessment, in which he is given a long explanation of the placebo effect (approximately 15 minutes in the IBS trial) as a powerful automatic body response. It turns out that in OLP treatment, clinicians must actively *manufacture* a situation in which the placebo effect makes sense. This involves introducing new propositions, definitions and practices to support the use of the phrase. Although OLP trials show how potential confusion about the placebo effect could be mitigated, the manufacture of the situation in which this is possible is no small task. In the example of the IBS trial, the explanation of the placebo effect alone is five minutes longer than the standard

26. Carvalho *et al.* (2016, 2020).
27. Kam-Hansen *et al.* (2014).
28. Kaptchuk *et al.* (2020).

general practice consultation in the UK.[29] Furthermore, the treatment occurred within the context of an academic medical trial, with clinicians actively and specifically focussed on promoting the placebo effect to patients who were selectively attracted to an advertisement for a novel mind-body treatment.[30] Given that, in everyday medical practice clinicians and patients do not even tend to talk about the placebo effect, it is difficult to see how the OLP treatment approach could be applied.[31] Let us consider example (2) again, to see how this might play out in an everyday setting.

After inquiring about Mr Hussain's symptoms, examining him carefully and going through some exercises he can do to help his back pain, Dr Andrews takes a different tack. Instead of suggesting some anti-inflammatory painkillers (which, in any case, she does not think will make much difference), she asks Mr Hussain if he knows what the placebo effect is.

> Oh yes doc. But are we at the stage where you've got to trick me into getting better!
>
> No, no Mr Hussain, not at all. You're far too smart for that! It's just that recent research has shown that taking placebo pills can stimulate an automatic self-healing response. Some studies suggest that this can be quite powerful, particularly for back pain like yours.
>
> Oh right. But you've blown it now by telling me about it!
>
> Oh right, well no, in the recent studies I'm talking about, the patients knew they were taking a placebo pill and they still felt better with it.
>
> Right, ok. Not sure how that works but I'll take your word for it. I'll take anything at this stage. But I'm not sure what you mean. What do I do?
>
> Well, we have some placebo pills I can prescribe...
>
> So I have to get them from the chemist? I'm not paying £7.95 for a load of placebos!
>
> Right, no, no, we have them here at the surgery. I can prescribe them directly. We can start with a four-week course then see how you're getting on?
>
> Ok. Just to ask doc, what exactly is in these pills then?

We can see from this short example some issues that might arise from introducing OLP treatment in an everyday clinical situation. Even with a

29. Kaptchuk *et al.* (2010).
30. These limitations are noted in the original article reporting the trial findings.
31. It is important to note that, in critiquing the manufacture of a situation to make sense of the placebo effect, I do not critique the more general process of manufacturing, constructing or enacting treatment situations for other ends. As much ethnographic research has demonstrated, the process of constructing, or better co-constructing, treatment situations might be an important aspect of medical practice. See: Hardman *et al.* (2020b), Hardman and Ongaro (2020), Mattingly (1998) and Mol (2002).

patient willing to try a new treatment, with whom Dr Andrews has a longstanding relationship, manufacturing a situation in which the placebo effect makes sense is much more difficult than in an OLP trial. First, Mr Hussain is not expecting any talk of the placebo effect. Dr Andrews has never mentioned it before, and Mr Hussain is not entering a situation in which he is primed for a 'novel mind-body treatment'. It is not like an OLP trial, where, before the first treatment is administered, the patient has already had a comprehensive explanation of the placebo effect in terms of self-healing capacity. Dr Andrews has to explain this in the flow of an ongoing consultation, which perhaps has only a few minutes remaining. How long will it take her to convince Mr Hussain of the benefits of OLP treatment? Even if she can, is it worth it? Would her time be better spent encouraging other ways in which Mr Hussain might relieve his back pain, such as staying active, stretching, and using hot and cold packs? These questions are difficult to answer, and the answers will be different for different patients, different clinicians and different situations. Such differences notwithstanding, manufacturing a situation in which the placebo effect makes sense is difficult because in many cases it involves changing the linguistic habits by which the clinician and patient normally interact. "Right, ok. Not sure how that works but I'll take your word for it," seems a reasonable response a patient might give to a clinician who introduced the OLP concept. The new definition of the placebo effect as a "self-healing response" seems to throw Mr Hussain off. It is not what he is expecting. He is not expecting to talk about the placebo effect, let alone redefine it. For the OLP treatment to have a chance of success, Dr Andrews has to win him over in short order. This seems like an unnecessarily difficult task even for a skilled clinician with a good relationship with their patient. OLP treatment, although not succumbing to the argument that the placebo effect obscures what can be better communicated more precisely, relies on an unrealistic and impractical process of manufacturing a situation in which the placebo effect makes sense. Given that clinicians do not generally have the time and resources to manufacture such a situation (and, in any case, regularly and straightforwardly use more settled words and phrases to promote many treatment effects the placebo effect purports to encompass), OLP does not seem like a worthwhile treatment to promote.

V. Conclusion

As I noted at the outset, the placebo effect is a troublesome and controversial phrase. I have tried to make sense of it by getting clear on how it

emerges in everyday situations. In research situations, particularly a randomised controlled trial, the placebo effect serves as a useful shorthand because of the practices that surround the use of the phrase. These practices support a common and useful pragmatic meaning of the placebo effect, even if its semantics are nonsensical. In clinical situations, however, there are no such supporting practices to provide intelligibility and, in any case, clinicians and patients have more settled words and phrases to promote treatment effects the placebo effect purports to encompass. Most clinicians and patients do not want to make statements about the placebo effect; those who do, have to manufacture a situation in which the statements make sense. The method of manufacture involves creating a new set of definitions, propositions and supporting practices. The most explicit example of this manufacture is open label placebo treatment, in which extensive resources and socio-academic capital are spent to make the placebo effect make sense. Given that most clinicians and patients do not have such extensive resources, and in any case do better with more settled words and phrases, the placebo effect does not seem a useful phrase in clinical practice.

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