

Should we be clinically exploiting the power of the placebo effect?

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Editorial

Wigley¹ produced a paper for debate in *Clinical Rehabilitation* entitled 'Placebo and time therapy: can they be used in rehabilitation and research?' This paper raised many important issues relating to the use of placebos in experimental research but, equally importantly, described the potential role for placebo therapy in clinical rehabilitation. Nine years have passed since the publication of that article, yet the debate regarding the role of placebo therapy in clinical practice has received scant attention.

The literal translation of the Latin term placebo means 'I please'. In clinical practice this is often interpreted as 'providing optimism and encouragement or tender loving care'.¹ It is well accepted that this type of care is of benefit to patients' biological, psychological and social well-being. In research, however, the term placebo is usually taken to mean a 'dummy' treatment which is believed to be ineffective. Patients are assigned to a control group which does not receive any experimental intervention.² The performance of this group provides a baseline against which the effects of treatment can be measured.³ This type of placebo treatment is predominantly associated with drug trials but has many other scientific applications such as the evaluation of transcutaneous electrical nerve stimulation for chronic pain.⁴

Despite the assumption that placebo treatment is ineffective, there is a wealth of information to the contrary. Indeed, Wigley¹ asserts that it is 'common knowledge' that placebo treatment does have an effect.

Rederich *et al.*,⁵ in a double-blind, crossover study of the acute treatment of migraine compared oral sumatriptan with placebo. While headache relief four hours postdose with sumatriptan was significantly greater than with

placebo, 18–23% of patients in this latter group still demonstrated significant relief. Levine *et al.*⁶ describe an increased endorphin production in association with such placebo analgesia.

In our own studies comparing different forms of skeletal muscle electrotherapy in the rehabilitation of quadriceps muscle function, elderly osteoarthritic patients receiving placebo electrotherapy demonstrated similar improvement in muscle function compared with patients receiving active treatment.⁷

Similar placebo effects to those described above have been attributed to the expectation that the placebo treatment will have an effect⁸. Indeed, some subjects may be more susceptible to displaying a placebo effect than others.¹ This is particularly apparent in the treatment of patients with psychiatric disorders.⁹

The whole area of placebo treatment is complex.¹⁰ It is apparent, however, that placebo treatments can be very powerful and I would argue that we should be debating their much wider use in clinical practice. There are many issues that need to be covered and, in particular, the ethical issues surrounding such initiatives. There are many benefits to this type of treatment, however, not least their cost-effectiveness and lack of side-effects.

Finally, I am in no way denigrating the role of placebo treatment in the evaluation of clinical trials. Rather, I would support the view of Wigley¹ that we must continue to evaluate our treatment against placebo controls but in choosing those controls we must be mindful of the potential power of the placebo effect. Indeed, we should be using the most potent sham treatments available in testing new and existing methods of treatment to ensure we are not observing a placebo effect and erroneously interpreting our results.

References

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