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The Reply

In response to Braillon,[1] we agree that conditioning and expectancy are mechanisms that explain part of both the nocebo and placebo effects, but nocebo and placebo are opposing in their actions; negative expectation can result in a worsening of symptoms, whereas positive expectation can improve symptoms. We would argue that "one [nocebo] can indeed be more powerful than the other [placebo]," as indicated in the review by Baumeister et al.[2]

Undoubtedly, the "doctor's duty is not to please but to help,"[1] but we are certainly not defining placebo effects as a method of "pleasing patients" or merely as the action of a dummy pill. By "placebo effect," we are describing nonspecific, context effects that arise from a variety of factors, including the whole sociocultural context of the use of the drug; the expectations; the health beliefs and prior experiences that the patients bring with them; the environment in which the prescriptions are given; the size, shape, and color of the pills used; and the nature of the interactions between patient and provider.[3-5] These are not "disease-mongering" and can have long-lasting effects.

Thus, one component of treatment that can affect patient outcome is the communication between the patient and the provider. Braillon states that poor professional relationships are "malpractice,"[1] but we argue that sometimes negative communication between doctor and patient can be unintentional; attempts to reassure the patient can leave the patient feeling misunderstood.[6] We do not argue that placebo should replace taking time, being open, and listening to the patient. Rather, these are likely to enhance the placebo effect that we describe.

Furthermore, we do not confuse compassion and empathy, but believe that attempts to be compassionate or to empathize do not necessarily help the patient, if such attempts are not *perceived* as such by the patient. We stress the importance of the intention of the words being successfully *transmitted* to the recipient and argue that sometimes (even unintentionally) we can be left feeling misunderstood. In essence, feeling misunderstood does matter.[7]

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References

1. Braillon A. The good, the bad and the empathic. *Am J Med*. 2015;128(8):e27.
2. Baumeister RF, Bratslavsky E, Finkenauer C, Vohs KD. Bad is stronger than good. *Rev Gen Psychol*. 2001;5:323.
3. Kaptchuk TJ, Kelley JM, Conboy LA, et al. Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome. *BMJ*. 2008;336:999-1003.
4. Howick J. Escaping from placebo prison. *BMJ*. 2009;338:b1898.
5. Doherty M, Dieppe P. The "placebo" response in osteoarthritis and its implications for clinical practice. *Osteoarthritis Cartilage*. 2009;17:1255-1262.
6. Linton SJ, McCracken LM, Vlaeyen JWS. Reassurance: help or hinder in the treatment of pain. *Pain*. 2008;134:5-8.
7. Greville-Harris M, Dieppe P. Bad is more powerful than good: the nocebo response in medical consultations. *Am J Med*. 2015;128:126-129.