Reviewer’s report

Title: The use of pure and impure placebo interventions in primary care: a qualitative approach

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Reviewer: Jon Tilburt

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In this article the authors to dig deeper into the meaning placebo use in clinical practice using a qualitative content analysis approach from semi-structured interviews of primary care physicians. They found that how their sample of physicians conceptualize placebo reflects of view of pure placebo. The practitioners did not equate “impure placebo” with the idea of placebo at all. Physicians also found the effects of CAM as often arising from a placebo effect. They felt unsure about regarding the ethical dimensions of whether and how to communicate about placebos to patients.

Many of their finding confirm my own biases about the topic, i.e.,
- The conceptual distinction between pure/impure both being placebos does not resonate
- Physicians do not know how to harness placebo with creating fundamental cognitive dissonance about their moral obligations
- Yet, a subset describe a degree of deception as legitimate on consequentialist grounds
- They implicitly apply impure placebo techniques that they would not characterize as such in difficult clinical circumstances in which mysterious or psychosomatic conditions are being addressed.

Despite these potentially insightful findings, I have some reservations about the approach described below in the Methods comments.

I would also like to see the limitations section better reflect the limitations inherent in their approach in terms of identifying all the relevant factors in clinician decision making, achieving thematic saturation, and the local nature of their sample.

Discretionary Revisions (which are recommendations for improvement but which the author can choose to ignore)

1. p.6 – “The interview(s) where analysed anonymously”

Discussion
2. “One of the main findings of our study is that placebo effects are often not recognised by physicians since their definition of placebo mostly fits to what is defined as pure placebo. One of the main findings of our study is that the physicians associate the term placebo with pure placebos and they do not consider therapies with unsure pharmacological effects as placebos in contrast to a scientist’s view.”

This style repeated in two successive sentences diminishes the quality of the writing and distracts the reader by using the identical opening language for both sentences.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

3. Abstract: The phrase “their use is controversial discussed” seem like a typo.

4. Background: The same (“their use is controversial discussed”) is said in the

5. p. 5 “we aimed to show potential differences in the use of pure as compared with impure placebos”. I think this purpose statement is slightly ambiguous. I believe they meant to say “we aimed to identify potentially important distinctions that practicing clinicians make in the use of and permissibility of pure vs. impure placebos”

Methods

6. Need to make explicit that sampling was from a “convenience sample” of practicing primary care physicians from one region in Switzerland.

7. “Further suggestions about how to conduct a placebo treatment provide Chaput de Saintonge et al. [18] and Lichtenberg et al. [23].” This sentence seems more like an administrative note, or else it did not translate well from another language.

8. Overall, I find it helpful if the format of a qualitative results section goes something like this,

• Overview of theme/subtheme
• Illustration with quote
• Summarizing statement of about what the them illustrates for the overall topic of the paper.

Major Compulsory Revisions (which the author must respond to before a decision on publication can be reached)

9. The semi-structured moderator’s guide should be available for review, not just the structural elements should be reviewed. Methodologically, need to insure that the questions aren’t “leading the witness”.
My concern for clarifying this is heightened by the analysis plan which basically says that after asking questions from 6 a priori categories, they then proceeded to code the transcripts not inductively using the constructs and terminology the physicians used, but their typology. This can be a legitimate analytic approach so long as physicians were given the liberty to take the conversation in a variety of less specified directions. Otherwise, the methodology becomes a survey with an open-ended response design rather that a true qualitative approach in which the final constructs or categories are discovered from not imposed on the text.

10. It is not clear whether data collection and analysis continued until the point of so called “thematic saturation”. If not, conclusions need to be further tempered to reflect the provisional nature of the findings.

11. Please clarify the language in which the interviews were conducted.

Results

12. This section is written with a tone that intends to quantify consensus, but tallying up physician remarks. Typically, I would be looking for a tone that is illucidating themes that emerged in the text and illustrating those themes. My concern is that the authors set out with the purpose of understanding what practicing clinician actually think about placebo, but because they had a pre-specified typology of what thematic issues were most interesting, they are left in the results section to tally up the categories from their typology. I find this approach less compelling.

13. On the definition of placebo, there is no comment on the extent to which placebo is even a helpful term. You might imagine that the term itself has been impose on clinicians with a perjorative gloss in a way that makes it difficult for them to conceptualize how it does fit in their practice. However, if left to their own self descriptions, physicians might rightly say that there are all sorts of ways in which meaning, context, expectation, and ritual influence their practice. But putting the term placebo out there early is a conversation stopper. This limitation should be acknowledged in the limitations section.

14. Under Placebo use in daily practice . . . I would find it helpful if there were subthemes that further refine what was discovered such as “ambivolence about proper role”, “relevant circumstances”, “what patients expect out of a visit”.

15. Under “Need for guidelines” there are no illustrative quotes. There needs to be some. Each of the inferences stated in this section needs to be substantiated with a quote or eliminated from the results section.

Discussion

16. Placebo definition subsection needs a concluding remark to tell the reader why the participants’ definition if found to be reflective of clinicians generally is so important. Something like, “these definitional differences create considerable challenges to facilitating a constructive professional discourse about the role of
placebos in clinical practice because . . . “

17. “The main finding regarding the use was that it is carefully adapted to the potential response.” This is a vague sentence. I don’t really know what this means.

18. “The ethical aspect in giving placebos to the patients played a central role.” It is impossible to know whether this finding is true because of the way the study was set up, i.e. how the questions were asked, or because, physicians, when given time to reflect on placebo generally naturally gravitate to their ethical ambivalence.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I have no competing interests