

WHAT YOU DON'T KNOW CAN HEAL YOU: A PHILOSOPHICAL INQUIRY INTO PLACEBOS

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Abstract

This paper explores the role of placebos in healthcare, particularly within Complementary and Alternative Medicine (CAM) and African Traditional Medicine (ATM), to highlight both the challenges and potential benefits of their use. It examines the scientific and moral issues surrounding placebos, such as concerns over deception, patient autonomy, and efficacy, while proposing possible solutions, including open-label placebos and the concept of contextual healing. The analysis argues that viewing CAM and ATM as systematic uses of placebo effects respects the cultural and communal aspects of healing present in these practices, which often utilise belief, ritual, and therapeutic settings as integral parts of the healing process. Additionally, the paper addresses epistemic injustices, specifically wilful hermeneutical ignorance, that arise when traditional and non-Western forms of knowledge are excluded from the conventional Western-centred healthcare practices. This marginalisation not only undermines the contributions of diverse healing traditions but also denies patients valuable therapeutic options. By acknowledging and integrating the placebo mechanisms at work in CAM and ATM, healthcare systems can adopt a more inclusive approach that respects cultural identities and supports holistic patient care. The paper concludes that, despite ethical and epistemological challenges, placebos within CAM and ATM have some legitimate therapeutic roles and present an opportunity for healthcare systems to address global health disparities.

Keywords: Placebos, Complementary and alternative medicine, Wilful hermeneutic ignorance, Biomedical ethics, African traditional medicine.

Introduction

The placebo effect is well-documented, and the need for placebo groups in well-designed clinical trials is widely acknowledged in medical research (ALNARSALLA & ALNARSALLA 2026; COENEN n.d.n. 2025; GUPTA & VERMA 2013). In recent years, a growing body of philosophical and biomedical literature has also examined the possibility of placebo use in clinical practice (FINNISS n.d.n. 2011; MILLER & COLLOCA 2009; PARDO-CABELLO n.d.n. 2022). This paper contributes to this discussion. Placebos, and more specifically the placebo effect, are an intriguing phenomenon in the realm of medicine, with *prima facie* surprising implications for treatment outcomes and patient well-being. Placebos are substances or interventions that lack specific pharmaceutical properties but can have a therapeutic effect on patients; on the face of it, largely due to patients' belief in the treatment's efficacy. These treatments can take different forms, such as sham surgeries and sugar pills, and have created a controversial debate regarding whether it is ethical to use placebos to treat illnesses and alleviate suffering from patients (FASSLER n.d.n. 2009;

HROBJARTSSON 2008; MILLER & COLLOCA 2009; TILBURT n.d.n. 2008). While some experts argue that the effects of the placebo should be harnessed to clinically treat patients to improve their well-being, most experts argue against the use of placebos because “adverse events can occur and [the patient’s] symptoms can get worse through a negative placebo effect, the so-called nocebo effect” (WEIMER n.d.n. 2020, 1). Traditionally, placebos have been (and still are) used in randomised controlled trials (RCTs) when assessing the efficacy of new drugs. RCTs are the “golden standard in research designs [and ...are] believed to provide the most definite test of efficacy” (PAPAKOSTAS & DARAS 2001, 1618). In an RCT, participants are (typically) randomly assigned to either the treatment group (receiving the active drug) or the control group (receiving a placebo). This isolates the specific effects of the treatment from those of the placebo (STANG n.d.n. 2005, 177).

CAM encompasses a wide range of treatments and practices that fall outside conventional medical approaches, which include but are not limited to homoeopathy, certain rituals performed in ATM. CAM therapies are often used in conjunction with, or as alternatives to, Western medicine, and are sometimes criticised for lacking rigorous scientific or pharmaceutical evidence. Interestingly, many CAM treatments have been shown to elicit significant placebo effects where the belief and expectation that CAM therapy will work can lead to real physiological and psychological improvements, similar to the effects observed with (pill-form) placebos (BEEDIE n.d.n. 2018; KAPTCHUK 2002). This suggests that the therapeutic rituals and the patient’s belief in the efficacy of the CAM treatment can induce the placebo effect, arguably justifying their practice.

I aim to advocate for the use of placebos in two ways: first, if CAM treatments demonstrate effectiveness and provide real benefits, primarily through the mechanisms of the placebo effect, they still fulfil the goal of medicine: to offer effective, beneficial treatment to patients. Assuming the aim of healthcare is to enhance patient well-being through reliable therapeutic outcomes, mainstream Western medicine should consider embracing placebos as a legitimate and valuable approach to treatment. Second, by arguing that CAM is largely a systematic use of treatments that harness the placebo effects, I draw from the existing literature on placebo effects to identify how these effects arise by examining the psychological mechanisms that generate them. I identify certain ritualistic practices in ATM that may operate primarily through placebo effects, illustrating how these therapies rely on the psychological mechanisms of placebos rather than pharmaceutical ones. This analysis of placebos can help us to better understand the role of placebos in healing and to argue for the possibility of CAM use (or indeed placebos in general) in mainstream medicine.

It is important to note that placebos and their effects span multiple disciplines, including psychology, clinical medicine, and neuroscience. My focus on the philosophical perspective may lead to an underrepresentation of insights from other fields, and while I touch on the relationship between placebos and CAM, I do not reduce CAM treatments to mere placebo effects. Nonetheless, I argue that from a scientific perspective, at least CAM, in particular ATM, will be reviewed as relying largely on the placebo effect. I undertake this project from a naturalistic approach; that is, I do not aim to prove the existence of supernatural entities and capabilities in terms of ATM. I operate on the assumption that since placebos work regardless of whether there is a supernatural dimension, an investigation into their systematic use in clinical treatment is warranted. At the heart of my research is the idea that dismissing CAM as unscientific or ineffective often reflects a form of “wilful hermeneutical ignorance” (POLHAUS 2012, 716). Wilful hermeneutical ignorance is the refusal to engage with knowledge systems that do not conform to dominant paradigms. CAM’s continued use across cultures, particularly in Africa, suggests that these therapies provide real benefits to patients, even if those benefits are often attributed to the placebo effect. Rather than seeing this as a limitation, I argue that the placebo effect itself deserves

serious attention. CAM treatments, through rituals, cultural context, and patient-practitioner relationships, may activate the placebo effect in ways that should be ethically and scientifically acknowledged.

I begin this essay by reviewing the current literature on placebos and placebo effects, exploring the various mechanisms of the production of placebo effects, and the contexts in which placebos can be used. I continue to discuss CAM treatment and highlight its distinction from mainstream medicine and how its healing process resembles that of placebo effects. Within this broader category, I examine ATM as a specific example of CAM. I then discuss ATM as a systematic use of the placebo effect, exploring its various rituals and mechanisms, and the importance of the therapeutic context. I also analyse the issues surrounding the use of placebos in clinical medicine and offer possible recommendations for these issues. Lastly, I defend the use of placebos by arguing that the dismissal of placebo mechanisms and the CAM practices that engage such mechanisms is a form of wilful hermeneutical ignorance, and recognising the epistemic injustices associated with dismissing traditional practices allows for a more equitable integration of diverse healing methods. By embracing the placebo effect as a legitimate part of the healing process, we can create a more inclusive and effective healthcare system that values both scientific and cultural wisdom.

What are Placebos and Placebo Effects?

Consider a group of three individuals suffering from a bacterial infection with flu-like symptoms, where it is expected that their condition will improve over a couple of weeks if left untreated. One individual, Ben, eventually feels better without taking any kind of medication, while Jen becomes better faster after taking some antibiotics. Ken, on the other hand, is offered a pill ‘disguised’ as an antibiotic, and he too feels better, slightly faster than Ben, but not so fast as Jen. This example reflects the three ways in which healing can take place, as suggested by Daniel Moerman (2002)¹. In the first case, Ben’s healing can be attributed to the body’s immune system releasing antibodies to fight off most viruses and bacteria, and in the second case, because Jen took antibiotics, her (faster) recovery can be attributed to the active pharmaceutical ingredients in that medication. Thirdly, Ken’s recovery involved a combination of the ways in which Ben and Lucy recovered, where “the act, though not the content of medicine, somehow triggers the body to autonomous healing” (WELCH 2003, 26). This is what a placebo effect is — a change in a patient's state that arises not from the specific physiological or pharmacological effects of the healing intervention, but rather from its symbolic significance (BRODY 1982). The ‘disguised’ antibiotic pill that Ken took is a placebo, and placebo interventions can be administered in various ways, ranging from physically taking the sugar pill, which can have physical effects like a reduction in pain, to psychological administration through conversation with a therapist, which can improve one’s mood. Placebo effects are not only seen in pseudo-medication and surgeries but also in medical treatments with active pharmaceutical properties. This can occur when medical treatments originally intended for one ailment are used to treat another. For instance, a patient presenting with influenza, a viral infection, can be prescribed antibiotics, used to treat bacterial infections. Due to the patient’s trust in the pharmacist and the expectation that the medication will work, they may get better faster than if they were to take no medication at all, despite the inefficacy of antibiotics against viral infections. Unfortunately, this may have contributed to the massive over prescription of antibiotics, resulting in an increasing number of drug-resistant bacteria (LINDE, FASSLER & MEISSNER 2011).

In the 1940s, at a Cornell Conference on Therapy, the terms “pure” and “impure” were first introduced to differentiate between various kinds of placebos (LOUHALA 2020,

¹ I discuss this more in the section on the healing process of CAM therapy and placebo effects.

26). Pure placebos are categorised as sugar pills and saline injections that lack pharmaceutically active ingredients to treat the targeted condition and impure placebos are treatments that do have pharmaceutical properties for certain illnesses but not specifically for the condition being treated, for example, prescribing vitamins to treat a viral infection (LOUHALA & PUUSTINEN 2017). This distinction, however, is problematic because pure placebos cannot be entirely chemically inert; they may have no pharmaceutical effect. However, placebos “are not without any effects since biological substances are never completely inert” (LOUHALA & PUUSTINEN 2017, 723). For instance, water can be used as a placebo; however, it has biological effects on the body (it cures dehydration and provides vital minerals). With ‘impure’ placebos, on the other hand, the categorisation of the three kinds of ‘impure’ placebos is problematic.

The first category of impure placebos is antibiotics being prescribed for suspected viral infections, where there is an assumption that the clinician prescribes them to a patient knowing they will likely be (pharmaceutically) ineffective against the infection². However, because patients present with different symptoms, accurately diagnosing or determining the cause of an infection is never easy (LOUHALA & PUUSTINEN 2017), and blood tests, which are typically not performed in the clinic for patients with flu-like symptoms, are not helpful. The second category of impure placebos is nonessential physical examinations and nonessential technical examinations of a patient; however, “the spectrum of physical or technical examinations that are ‘essential’ for a particular patient is highly dependent on the context” (LOUHALA & PUUSTINEN 2017, 723). This means that the way the patient describes their symptom or the way in which they come in to see the doctor can influence the extremity of measures taken by the doctor. Thirdly, positive suggestions require the clinician to give hope and comfort to their patients by showing that they have faith in a particular treatment, which could be meaningless if that treatment is described merely as lacking any pharmaceutical effect (LOUHALA & PUUSTINEN 2017). Patients then will not believe in that treatment’s efficacy, and nocebo effects can occur. The distinction between ‘pure’ and ‘impure’ placebo highlights the ambiguity and irrelevance of having such a distinction in the first place.

One of the placebo’s most important qualities is its ability to simulate immune responses, resulting in better health outcomes without having any active components that could impact the illness being treated. In some cases, placebo therapies can produce measurable effects on health, which can be either positive or negative. For example, a nocebo effect may occur when an individual expects the intervention to cause harm or does not believe that the intervention will work. These effects, which can manifest as drowsiness or nausea, are commonly seen in healthy individuals who, when given a placebo, experience adverse reactions because they do not expect any medical benefit from the treatment (PAPAKOSTAS & DARAS 2001). It is important to distinguish between placebos and nocebos. A placebo, by definition, involves an intervention that can produce a measurable positive effect on health, typically through positive expectations. A nocebo, on the other hand, refers to adverse outcomes that result from negative expectations or beliefs about an intervention. Both placebo and nocebo effects demonstrate the significant role that patient perception, expectations, and belief play in health outcomes, highlighting the psychological and physiological mechanisms that can influence the efficacy of treatments. While placebos have been shown to alleviate pain and manage symptoms in patients, nocebo effects are a legitimate concern due to the expectation of harm held by patients. The nocebo effect can be mitigated through ethical practices such as clear communication between patient and

² It is worth noting that this is bad practice on the part of the clinicians since overprescription of antibiotics is arguably driving the rise of drug-resistant bacteria.

clinician, patient education, and minimising unnecessary medical jargon that might induce anxiety in the patient. The benefits of placebos extend beyond individual health to include increased accessibility to treatments, particularly in resource-limited settings, and the validation of diverse cultural healing practices. Thus, with careful management of the risk associated with nocebos, the therapeutic potential of placebos offers an advantage in advancing patient-centred care. So, what makes it possible for a placebo to have an effect on an individual?

There are several theories that explain the mechanisms of the placebo effect. I will review two of those theories: conditioning theory and expectancy theory. These two theories are often considered mutually exclusive because each offers different perspectives and explanations of placebo effects at different levels of healing (KOSHI & SHORT 2007). In the next two subsections, I will discuss the two theories and analyse how each theory affects the production of placebo effects in patients.

The Conditioning Theory

The conditioning theory “suggests that placebo response [used interchangeably with placebo effect] represents a form of classical conditioning that is based on learning through association” (KOSHI & SHORT 2007, 6). Classical conditioning is a learning process where a previously neutral stimulus elicits a conditioned response after being associated with a stimulus that naturally brings about that stimulus (STEWART-WILLIAMS & PODD 2004). This learning process has several key features. An unconditioned stimulus (US) is a stimulus that naturally causes a reaction or response without prior learning. An unconditioned response (UR) is the natural response that occurs naturally in reaction to the US. A natural stimulus (NS) is a stimulus that previously does not trigger any intrinsic response. A conditioned stimulus (CS) is the previously neutral stimulus that eventually triggers a conditioned response after it is associated with the unconditioned stimulus. Lastly, the conditioned response (CR) is the learned reaction to the conditioned stimulus. In the context of placebos and their effects, “a placebo is a conditioned stimulus, and a placebo effect a conditioned response” (STEWART-WILLIAMS & PODD 2004, 329).

A classic example is Pavlov’s experiment with dogs. A bell, initially a neutral stimulus, was rung repeatedly alongside the presentation of food. The food is an unconditioned stimulus that naturally causes salivation, an unconditioned response in dogs. Over time, the dogs associated the bell’s sound with food and, as a result, they began to salivate at the sound of the bell, even when no food was present (PAVLOV 1927). This same phenomenon occurs in humans, where a patient can associate a certain procedure or medication with pain alleviation. This works as follows: a patient with a headache takes paracetamol (US) and experiences a reduction in pain (UR), and the paracetamol has a specific shape and colour (NS). There then becomes an association formed between the paracetamol (NS) and pain alleviation (UR). So, if we give a patient with a headache who regularly uses paracetamol tablets for back pain a pill that resembles paracetamol in shape and colour, a placebo effect is likely to occur, and the pain could be reduced. This is because after several instances, the placebo alone (which is now a CS) can trigger pain relief (CR). The patient’s response to the tablet happens subconsciously without them realising it. This response is influenced by the individual’s past learning experiences, often referred to as response generalisation, and according to this model, the variability in placebo responses among individuals can be attributed to their previous medical history and their unique experiences of learning from specific treatments in particular environments (KOSHI & SHORT 2007). As a result, even in the absence of active treatment, significant improvements in health outcomes can be achieved through the process of learning associations between a

neutral stimulus (such as a pill) and a therapeutic response, which is the basis of classical conditioning for the placebo effect.

The Expectancy Theory

Another theory that explains the mechanism of the placebo effect is the expectancy theory. It is a psychological theory that was developed by Arnold Goldstein in 1962. The expectancy theory suggests that the response to a placebo is linked to the patient's expectations of getting better, which are associated with the observed changes (KOSHI & SHORT 2007). This theory suggests that when a patient is expecting to receive treatment or a procedure, their response to the treatment could override the actual pharmacological effect of the drug — it is their mere belief that the treatment will have a beneficial effect that can lead to real, measurable changes in their health or behaviour. This approach suggests that “placebo effects are a subcategory of expectancy effects, and placebos are an expectancy manipulation” (STEWART-WILLIAMS & PODD 2004, 328).

There are several components of the expectancy theory in placebos: firstly, expectations. The central premise here lies with a person's expectations about the efficacy of a treatment — if that person expects the treatment to improve their symptoms, they are more likely to experience an improvement. Edwin Koshi and Christine Short also argue that these “expectancies can even override the pharmaceutical effect of a drug” (2007, 7). The second component of the expectancy theory is cognitive processes. This theory posits that “cognitive ... factors are capable of interacting with neurochemical systems in the body” (KOSHI & SHORT 2007, 10). This means that when a person is anticipating a positive outcome from a particular treatment, their brain may release neurotransmitters like endorphins that can produce the expected pain relief, which in this case is a placebo effect. Thirdly, past experiences with medication can shape a person's current expectations about treatment. This theory argues that “patients' expectations (faith or hope) are largely learned through patients' past contact with the medical system” (KOSHI & SHORT 2007, 13). This theory attributes the responsibility for the placebo response to the medical system rather than the patient. It hinges on the system's ability to effectively treat the patient. Every interaction an individual has with the medical system shapes the placebo response (KOSHI & SHORT 2007, 13). Lastly, the expectancy theory is rooted in contextual cues. The environment and context in which the placebo is administered can influence expectations. Factors such as the appearance of the pill, the demeanour of the healthcare practitioner, and the medical setting can all enhance the patient's belief in the treatment's efficacy (KOSHI & SHORT 2007).

So, the expectancy and conditioning theories propose that the placebo effect is a learnable phenomenon, occurring either consciously or unconsciously. In the conscious scenario, repeated associations between contextual cues and the outcome may lead to heightened expectations and in the unconscious scenario, a form of Pavlovian conditioning may occur where contextual cues and outcomes are linked without conscious awareness due to their proximity (KOSHI & SHORT 2007).

The discussion above reveals that placebo effects emerge from psychological and contextual mechanisms rather than pharmacological action alone. Before considering how such mechanisms may operate within the context of CAM, specifically ATM, it is necessary to first clarify what is meant by CAM. In the next section, I briefly conceptualise CAM and outline its distinctions from conventional medicine.

What is Complementary and Alternative Medicine?

CAM represents a wide spectrum of healing philosophies and treatments that lie outside of the conventional Western-centred clinical medicine and healthcare practices, and that can be used in collaboration and interchangeably with (or even as a replacement to) conventional

medicine and healthcare practices (MUSKIN 2008). CAM treatments often present themselves as a more holistic and personalised approach and are described by their users as “preventing or treating illness or promoting health and well-being” (PAL 2002, 518). The term alternative refers to any modal of treatment used as a substitute for conventional treatment methods, whereas complementary refers to the combining both alternative medicine and conventional medicine and using both modalities of treatment alongside (they complement) each other (SNYDER n.d.n. 2014). For this paper, I will not be scrutinising the distinction between the two. Rather, I adopt the term complementary medicine to encompass both alternative and complementary aspects of CAM because complementary medicine has shifted from only describing the ‘complementary’ relationship between conventional mainstream medicine and alternative medicine to describing the entirety of CAM itself (PAL 2002).

The distinction between CAM and conventional medicine is shaped by the medical frameworks within which healing practices are evaluated. The difference lies in the emphasis of the former on spirituality and holism. And the latter on materialism, where “physical matter is the only or fundamental reality, and that all beings and processes and phenomena are manifestation or result of matter” (PAL 2002, 519). So, this means that proponents of conventional medicine adopt a naturalistic, objective view of health and disease, looking strictly at the bodily effects of healing and disease and not subjective thoughts or emotions about the body and its relationship with the mind or spirit. Conventional medicine works with the biomedical model, which focuses specifically on biological processes and physiological interventions for curing and treating disease, whereas CAM may prioritise more holistic approaches that emphasise the patient’s overall well-being, psychological aspects, or energy-based concepts, even when they aim for healing. The biomedical model is thought to reduce the patient’s active participation in their recovery; they are only questioned about their symptoms, medical history, and lifestyle, several tests are conducted, the doctor provides a diagnosis based on the results of those tests, and a treatment plan is then prescribed (SZAWARSKA 2017). Although there is no direct refutation of spirituality, culture, or religion, conventional medicine does not consider these factors in the diagnostic and healing process of patients (PAL 2002). It is all about the physical body and its functionality, or the lack thereof.

CAM, on the other hand, often emphasises the power of spirituality and “energy”, and how, if negatively affected, this energy can lead to disease and so the disease is not only viewed as the deterioration of the body but as the imbalance of the body’s energies (PAL 2002, 519). Thus, for CAM, healing involves directing energy flow to restore balance throughout the patient, not simply at the location of discomfort (PAL 2002, 519). Proponents of CAM can be viewed as normativists, who “reject [the] claim to objectivity and maintain that health and disease are essentially value-laden” (KINGMA 2010, 242). CAM typically adopts a subjective view on disease and prioritises how an individual feels about a particular condition, and the patient plays an active role in their healing process in collaboration with the practitioner.

Now that the general features of CAM have been identified, it is helpful to look at a specific example within this broader category. ATM provides this because its healing practices often operate through psychological mechanisms as placebos and context mechanisms like belief, ritual and the therapeutic relationship between patient and practitioner. In the following, I therefore examine how these mechanisms could contribute to therapeutic outcomes in ATM.

African Traditional Medicine: A Systematic Use of the Placebo Effect

African Traditional Medicine (ATM) is a broad system of healthcare that incorporates herbal remedies, spiritual rituals, and divination, deeply rooted in the cultural and spiritual traditions of African communities. In South Africa, for instance, these therapies are often performed by diviners and herbalists where “the herbalist is concerned with medicines made from plants and animals and the diviner is a spiritualist, using divination for healing purposes” (BRAUN 2009, 503). Similar to how doctors who practice conventional Western medicine have to go to universities to get medical degrees in order to practice medicine, ATM practitioners are “required to be initiated into a secret society, as many characteristics of this form of medicine can only be passed down to initiates” (OZIOMA & CHINWE 2019, 192). For example, those with a spiritual calling would go to initiation schools in the wilderness to be taught how to use their gifts. When considered from the perspective of the placebo effect, ATM functions as a powerful healing system largely due to the psychological and social mechanisms it engages, alongside any potential pharmacological benefits of its remedies.

ATM has a history that is as varied as the continent. Before the introduction of Western medicine to Africa, its origins date back thousands of years. Depending on their surroundings and cultural values, every ethnic group has created its own special medical customs. For example, the Akan people use an amulet made of plants and animal parts as a healing instrument. They believe that it “[brings] the power of the ancestor to bear on all conditions surrounding the living” (ASANTE & MAZAMA 2009, 44). In the centuries that followed, the transmission of knowledge about medicinal plants, healing rituals, and spiritual practices became an oral tradition and healers, often referred to as herbalists, diviners, or traditional spiritual healers, held important social roles within their communities (ASANTE and MAZAMA 2009). The arrival of colonialism and the introduction of Western medicine led to the marginalisation of ATM; however, it remains widely used, especially in rural areas where access to formal healthcare services is limited. For instance, in South Africa, ATM practitioners, also referred to as Traditional Health Practitioners (THPs) are “highly respected and serve approximately 60% of the people of South Africa [and these] healers ... greatly outnumber Western-medicine doctors at a rate of 8:1” (BRAUN 2009, 503).

Rituals and Belief Systems in ATM

Using rituals and belief systems is one of the main ways that ATM works as a methodical application of the placebo effect. The purpose of ATM healing rituals is to harmonise the patient's mental, spiritual, and bodily states as “illness is regarded as having both natural and supernatural causes and thus must be treated by both physical and spiritual means, using divination, incantations, animal sacrifice, exorcism, and herbs” (OZIOMA & CHINWE 2019, 193). The role of belief is crucial here — when a patient participates in these rituals, they are immersed in a culturally meaningful context where their faith in the treatment, the healer, and the process itself can enhance their expectation of recovery. Research on the placebo effect has shown that positive expectations can directly influence the brain's pain-processing pathways, leading to measurable changes in symptoms (BENEDETTI n.d.n. 2005). For example, after going through a ritual cleansing or divination process, a patient with chronic pain may feel better, not because the ritual changes the physical source of the pain but rather because the patient's belief in the ritual's effectiveness causes a positive psychological reaction. This is also seen in Western medicine, where the patient can feel better after consulting with a general practitioner, before even taking the medication, because of the diagnostic ritual of using a stethoscope or conducting an ultrasound on the patient. As a kind of placebo, the ceremonial setting activates the patient's natural healing mechanisms.

Herbal Remedies and Symbolic Significance in ATM

While ATM is commonly known for its use of herbal remedies, many of these treatments carry symbolic significance that aligns with the beliefs and expectations of the patient (SOFOFORA 1996). Certain kinds of herbs might be chosen for their spiritual associations or the belief that they carry specific healing energies. In these cases, the placebo effect plays a role alongside any potential pharmacological effects. Even when herbal treatments have active ingredients, the patient's belief in the symbolic power of the herb can enhance its effectiveness. For example, *Artemisia annua* (artemisia) is used for its anti-malarial properties but it is also recognised for its reference to “the Greek goddess Artemis, daughter of Zeus, twin sister of Apollo, and credited with... averting evil” (FERREIRA n.d.n. 2004, 57). This dual action, where both belief in the remedy and its physical properties contribute to healing, shows how ATM operates systematically through elements of the placebo effect. The cultural context gives meaning to the treatment, reinforcing the patient's positive expectations and the perceived potency of the remedy.

ATM and the Therapeutic Context

The concept of contextual healing is crucial to understanding how ATM functions as a systematic use of the placebo effect. The term, popularised by researchers like Daniel Moerman (2000), refers to the healing that results from the broader context of the therapeutic encounter rather than the specific active ingredients of a treatment. In ATM, the healing space, the relationship between the healer and the patient, and the traditional practices that surround the treatment all contribute to creating a powerful therapeutic environment (WELCH 2003). For example, the use of traditional shrines, sacred spaces, and ceremonial objects in ATM provides a healing environment that is imbued with cultural significance. These elements serve as cultural placebos, providing reassurance and comfort to the patient through their symbolic meaning (TSEY 1997). The therapeutic context in ATM thus becomes a catalyst for psychological processes that contribute to physical healing, making the placebo effect an integral part of the treatment.

Issues Surrounding the Use of Placebos and Possible Responses

One of the primary ethical concerns surrounding the use of placebos is the potential for deception. Traditionally, placebos have been used in clinical trials as a control to test the efficacy of new treatments, with patients unaware of whether they are receiving an active treatment or a placebo, and this can “reinforce the notion that placebo effects can only be induced through deception” (FRIESEN 2019, 1). Many experts argue against the use of placebos even in clinical trials as they are seen as unprofessional and unethical (STANG n.d.n. 2005). Richard Cabot made the claim that “every placebo is a lie, and in the long run the lie is found out” (FRIESEN 2019, 2). More recently, Mark Arnold n.d.n. explained the situation as follows: “intentional, or incidental/unintentional use of the placebo effect is characterised as deceptive, unethical, unscientific, and unprofessional” (ARNOLD n.d.n. 2015, 80). Adam Kolber also notes that some people refer to placebo treatments as medicine's “dirty little secrets” (KOLBER 2007, 75). This raises concerns about violating the principle of informed consent, which is foundational in modern medical ethics. Deceiving patients, even with good intentions, can “undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient” (KAPTCHUK n.d.n. 2010, 1). For example, in the context of ATM, traditional healers might use treatments like ritualistic cleansing or herbal remedies that lack scientifically proven active ingredients. If patients believe these treatments to have direct curative powers, rather than understanding their potential placebo effects, critics argue that this could be seen as deceptive (ASANTE &

MAZAMA 2009). This ethical dilemma centres on whether it is justifiable to withhold information about the true nature of the treatment if it results in a positive outcome.

In response to this ethical challenge, open-label placebos offer a promising alternative that preserves the autonomy of the patient. Open-label placebos represent a new approach to placebo use that prioritises ethical transparency by fully disclosing the nature of the treatment. In an open-label placebo intervention, patients are informed that the treatment has no active pharmaceutical properties, but that studies have shown that people can still experience symptom alleviation due to the placebo effect (CARVALHO n.d.n. 2016). For example, in a study on patients with irritable bowel syndrome (IBS), it was discovered that patients who knowingly took open-label placebos “in the context of supportive patient-practitioner relationship and a persuasive rationale had clinically meaningful symptom improvement” (KAPTCHUK n.d.n. 2010, 4-5), demonstrating that belief and the ritual of taking medication itself can promote healing without the need for deception. The mechanism through which open-label placebos work remains a subject of research, but it is suggested that they tap into a patient’s belief (expectancy) in the healing process and the routine of medical care (conditioning). In ATM, treatments such as the use of protective amulets or ceremonial rituals can be understood to work through the therapeutic context and belief systems surrounding them rather than through active practices. This approach aligns with open-label placebos, as patients are aware of the symbolic function of the treatment. Furthermore, since (I would assume at least most) traditional healers genuinely believe in the effectiveness of their rituals, there is no real deception involved. This open and honest approach allows the patient to make an informed choice about participating in a placebo-based treatment, aligning with the values of autonomy and respect in clinical care and challenging traditional assumptions about the need for patient deception to trigger a placebo effect.

Another issue surrounding the use of placebos in treatment is the question of scientific efficacy. Critics argue that placebo effects lack measurable and consistent outcomes, challenging the scientific bias for the use (WEIMER n.d.n. 2020). Western biomedical practices prioritise treatments with clear mechanisms of action and proven effectiveness in controlled trials and this leads to the marginalisation of therapies that operate primarily through mechanisms similar to that of the placebo, as many CAM practices do. Placebo outcomes can vary significantly depending on factors such as patient expectations, the clinical setting, and the patient-practitioner relationship, making it challenging to isolate consistent causal pathways (KAPTCHUK 2011, 6). This ambiguity in mechanism makes it difficult to predict and control placebo responses in clinical care, raising concerns about the reliability of placebos as legitimate treatment. A core tenet of evidence-based medicine is the reproducibility of outcomes. Placebo effects, however, are highly variable across individuals and contexts, with some patients experiencing significant relief while others experience none or adverse effects (i.e., nocebo effect). In clinical studies, placebo responses can be as high as 50% for conditions like chronic pain and depression, but there is no guarantee of effectiveness in every case (BENEDETTI n.d.n. 2005). This variability challenges the reproducibility and standardisation that are foundational to scientific medicine and fuels scepticism regarding placebos’ reliability in routine care.

A response to the concern about scientific efficacy is to broaden the understanding of what constitutes healing. The concept of contextual healing suggests that healing can occur through the context and meaning ascribed to a particular treatment, rather than solely through its pharmaceutical effects (MOERMAN 2002). By focusing on the therapeutic relationship, the environment of care, and the patient’s expectations, this approach recognises that psychological and social factors are integral to the healing process. An example of this can be seen in the practice of cleansing rituals in ATM, where a healer may conduct a ceremony

to remove negative spirits believed to be causing illness (ASANTE & MAZAMA 2009). While the ritual may lack scientific backing by Western standards, it can provide psychological reassurance, reduce stress, and even alleviate symptoms through belief and expectation. By recognising the value of these elements, ATM can be seen as offering a form of healing that is complementary to, rather than in competition with, mainstream approaches.

An Epistemic Defence for Placebos and CAM

In contemporary healthcare debates, the marginalisation of ATM and other CAM practices raises significant questions about epistemic injustice. This term, introduced by Miranda Fricker in *Epistemic Injustice: Power and the Ethics of Knowing* (2007), describes the harm that occurs when individuals or groups are wronged specifically in their capacity as knowers due to “prejudices about the speaker, such as gender, social background, ethnicity, race, sexuality, tone of voice, accent, and so on” (BYSKOV 2020, 114). In the context of medicine, epistemic injustice arises when non-Western forms of healing, such as ATM, are dismissed or undervalued because they do not conform to Western biomedical standards, and this perpetuates a form of hermeneutical ignorance. This dismissal perpetuates inequities and hinders the integration of diverse perspectives into healthcare, potentially limiting holistic approaches to patient care. Those in positions of authority uphold an epistemological hierarchy that prioritises Western knowledge while marginalising non-Western healing traditions by keeping ATM and CAM out of public funding and healthcare institutions (GOLDSTEIN 2022). Patients who are excluded may be compelled to seek care outside of the official healthcare system, which has a negative social and financial impact on them. Additionally, it denies people the freedom to select medical treatments that are consistent with their values and beliefs. This type of unfairness is particularly noticeable in communities with limited access to healthcare resources, where alternative healing methods offer practical solutions. Exploring how epistemic injustice manifests in healthcare settings reveals an ethical need to recognise and integrate diverse healing practices, both for their cultural significance and for the psychological and social benefits they provide.

One key concept related to epistemic injustice is wilful hermeneutical ignorance, which describes “instances where marginally situated knowers actively resist epistemic domination through interaction with other resistant knowers, while dominantly situated knowers nonetheless continue to misunderstand and misinterpret the world” (POHLHAUS 2012, 715). This ignorance is evident in the exclusion of ATM from mainstream healthcare, where it is dismissed as unscientific. This exclusion is not necessarily based on a lack of evidence but often on a reluctance to adapt or expand the parameters of acceptable knowledge. However, ATM plays an important role in many African communities, encompassing not only healthcare but also elements of cultural identity and social cohesion (MOKGOBI 2014). For instance, ATM incorporates elements of ritual, symbolism, and communal practices to promote healing. When such practices are disregarded due to their non-conformity to Western biomedical standards, wilful hermeneutical ignorance emerges, and this constitutes a form of epistemic injustice that undermines the historical traditions and lived experiences of ATMs practitioners and beneficiaries.

To address epistemic injustice in healthcare, there is a moral imperative to value diverse healing traditions and incorporate their insights into our understanding of health and illness. Recognising the therapeutic potential of ATM and other CAM practices, particularly through the placebo effect, can pave the way toward a more inclusive approach to healthcare that respects cultural contexts. Indeed, ATM could in principle be carefully integrated into broader healthcare systems as a complementary practice, honouring its psychological and social benefits without dismissing it on purely biochemical grounds. Research into the placebo mechanisms of ATM could further bridge the gap between traditional and modern

medicine, fostering a healthcare environment that respects the cultural values and beliefs of its patients. Funding such research not only legitimises ATM's role in healthcare but also acknowledges that healing is a multidimensional experience, shaped by cultural and communal elements. This approach respects the cultural integrity of ATM practices and opens a path for more equitable healthcare systems that value diverse knowledge systems. The placebo effect, far from being a deceptive or ineffective treatment, can be a legitimate and powerful tool for promoting health and well-being. Funding and supporting ATM and CAM practices could enhance healthcare systems' ability to address patient needs, particularly in areas where conventional treatments are unavailable or unaffordable. Thus, governments and healthcare institutions have an ethical responsibility to support culturally aligned treatments for communities where these practices hold significant cultural importance. Funding CAM practices would allow healthcare systems to offer a more diverse range of healing options and address the psychological and cultural needs of patients. For CAM practices and placebos to receive public funding, the treatments should demonstrate measurable benefits, whether through symptom relief and improved quality of life (RCTs, neurobiological evidence like functional Magnetic Resonance Imaging (fMRIs) and patient-report outcomes) or cultural and psychological well-being where in psychiatric care, a Sangoma might make for a better counsellor for people who share their cultural heritage and belief systems than a western-trained counsellor. This inclusive approach not only respects the autonomy of patients in choosing treatments that resonate with their beliefs but also promotes global health equity by honouring diverse ways of knowing.

Conclusion

In conclusion, the use of placebos and CAM, like ATM, within conventional healthcare practices is not merely an issue of efficacy but one deeply rooted in epistemic and moral considerations. By disregarding ATM and the potential therapeutic power of placebos, Western biomedical models perpetuate epistemic injustice and wilful hermeneutical ignorance by actively marginalising cultural practices and the knowledge systems that support them. This exclusion limits patient access to a broader range of healing practices that could enhance well-being through culturally relevant, contextually grounded, and psychologically beneficial methods. Furthermore, understanding the placebo effect as more than deception but as a legitimate therapeutic approach aligns with expanding definitions of healing, which acknowledge the integral roles of belief, ritual, and context. The ethical obligation to integrate placebos and ATM into healthcare arises from a need to respect and validate diverse knowledge systems, ensuring that healthcare practices are inclusive, culturally sensitive, and attuned to the holistic needs of patients. Open-label placebos, for example, offer transparency and harness the power of patient expectations, proving that placebo effects can be ethically achieved and therapeutically valuable. Similarly, recognising ATM within conventional healthcare practices allows patients to pursue treatments aligned with their cultural values, ultimately fostering a more equitable healthcare system that respects diverse pathways to health. As healthcare systems strive toward inclusivity, integrating practices like ATM and leveraging the placebo effect holds the potential to bridge gaps in patient care, reduce epistemic biases, and foster a richer, more culturally competent healthcare environment. In doing so, we not only remedy an ongoing epistemic injustice but also fulfil a moral duty to provide comprehensive, culturally respectful, and effective healthcare.

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