

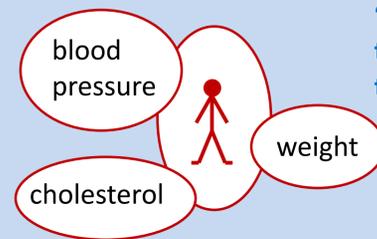
“Seeing a need” to take preventative pills: two different kinds of information that influence decisions



This data is drawn from a qualitative study about deciding whether to take statins, based on interviews with people who have been offered them.

Numbers which describe **the current state of the body** often act as a trigger for action.

**“my cholesterol had gone up to 9...
so I thought perhaps I ought to do something about it”**



“I’m happy to take them, and watch the hard evidence of the blood test every 6 months to see what’s happening to that cholesterol level”

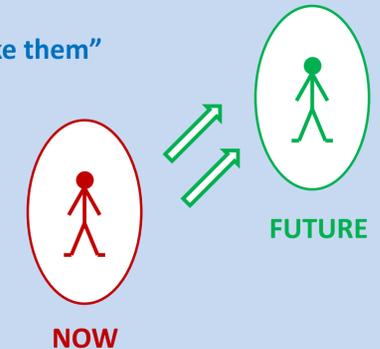
“my blood sugars were bad, I mean they were always around 10... but now I am on this it’s like 5.6, 5.7”

Risk information seems to be different from ‘current state’ information:

“the 4%....didn’t seem to me much”

“It’s a preventive thing and you haven’t seen any... need to take them”

“ I wouldn’t take it myself, just by... having that sort of evidence presented to me, it would have to be a very personal thing”



‘distributed embodiment’ Radstake, in *Blaxter* / ‘the quantified self’ Lupton

‘irreducible uncertainty’ Spiegelhalter

Communicating risk is a much-studied topic, with ‘how to present risk numbers clearly’ at its centre. Many interviewees in this study take pills to reduce risk of future illness, but in talking about this **they mention risk numbers remarkably little**. Instead, they talk about being **“sufficiently frightened by the prospect of what the doctor told me”**. The only risk numbers which they do report being influenced by are everyday ones, used rhetorically and in a very personal way: **“the doctor said to him, with blood pressure like this you would have a major stroke or heart attack...within 18 months to 2 years”**

Gale et al (2011) have shown that people do not use their risk numbers in decision-making even when carefully taught to understand them; this study provides some evidence to support this finding. **In contrast, interviewees often talk about their numerical test results as triggers or goals for action**, echoing Blaxter’s account (2009) of her test results as being incorporated into her (distributed) embodiment alongside haptic sensations. The two-way interaction people describe with their test results, both being influenced by them and seeking to influence them, is similar to that described by Lupton (2013) in the context of self-tracking.

So, numerical information about the body often gets used in health decision-making, but numerical information about future risk does not. **A possible explanation for this difference** lies in the tacit common knowledge that the future is ‘irreducibly unpredictable’; lay knowledge about candidacy always includes exceptions like Davison’s ‘Uncle Norman’ (1991). It seems likely that individual, everyday practices, like those studied here, are informed by what Bourdieu (1990) calls a practical logic based upon this tacit knowledge, rather than the theoretical type of logic through which risk numbers are derived from an overview across a large population.

Hacking (1975) describes the ‘taming’ of chance by statisticians in recent centuries, yet for most people risk numbers are still not tame enough to use when making decisions. Unlike **“the hard evidence”** of a cholesterol level, attaching a risk level to a particular individual is inherently an uncertain business – it can never be **“a very personal thing”**. **Instead of risk numbers, it seems many people are influenced by the opinion of a reputable authority**: this opinion is what used to be named ‘probability’ until the eighteenth century. The meaning of the word has changed as the concept of probability has evolved, yet a twenty-first century interviewee still says risk numbers would not persuade him to take tablets: **“a GP would have to say ‘Yes! aspirins would definitely help, you know, your particular case”**.

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