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What is wrong with “being a pill-taker”? The special case of statins

Abstract

In an interview study of decision-making about statins, many participants said they took pills regularly, yet described themselves as 'not really pill-takers'. This paper explores this paradox and its implications. The practice of pill-taking itself can constitute a challenge to the presentation of moral adequacy, beyond the potential for rendering stigmatised illnesses visible. Meeting this challenge involves a complex process of calibrating often-conflicting moral imperatives: to be concerned, but not too concerned, over one's health; to be informed, but not over-informed; and deferential but not over-deferential to medical expertise. This calibration reflects a broader tension between rival tropes: embracing medical progress and resisting medicalisation. Participants who take statins present them as unquestionably necessary; 'needing' pills, as opposed to choosing to take them, serves as a defence against the devalued identity of being a pill-taker. However, needing to take statins offers an additional threat to identity, because taking statins is widely perceived to be an alternative strategy to 'choosing a healthy lifestyle'. This perception underpins a responsabilising health promotion discourse that shapes and complicates the work participants do to avoid presenting themselves as 'pill-takers'. The salience of this discourse should be acknowledged where discussions of medicalisation use statins as an example.

Introduction

'The....scenario - of whole populations taking a daily tablet to mitigate against unhealthy lifestyles - is far from attractive' (Smeeth and Hemingway, 2012)

Smeeth and Hemingway's comment, written in response to a recommendation (Mihaylova and al, 2012) that statins should be offered at a lower threshold of cardiovascular risk than before, indicates a distaste for the idea of widespread pill-taking. Such distaste has become a trope over several decades, yet during these same decades people have come to take more pills than ever. This apparent paradox is explored in the study reported here, which looks at how participants talk about statin decisions. Many participants say they take pills regularly but also say they are not 'pill-takers'. This article explores what people mean by 'being a pill-taker', how they avoid presenting themselves in this implicitly undesirable way, and why it is particularly hard to legitimate statin-taking.

Although offering statins to more people has been incorporated into health policy in the UK (NICE, 2014), the recommendation is the subject of ongoing controversy (Parish et al., 2015). In part, this controversy reflects a clash between two different discourses, with 'a pill for every ill' (Huxley, 1932) cast as a desirable goal of medical progress within a primarily-biomedical discourse, but as 'the spectre of a medicalised and medicated society' (Crawford, 1980) within a social science discourse. Central to this clash is an extension of the medical gaze outward from its old focus on sick individuals to encompass the whole population, redefining an 'ill', or medical problem. Armstrong (1995) describes this extension as making a central contribution to the evolution of 'surveillance medicine'. His thesis is illustrated by considering cardiovascular disease and statins: as well as having illnesses like heart attacks or angina, individuals may now be diagnosed as being 'at risk' of future heart attacks and offered statins to reduce this risk.

From the 'medical progress' perspective implicit in most biomedical research and practice, an expansion of the group of people who have an identifiable, treatable medical problem is to be welcomed, increasing the number of people who can benefit from medical interventions.

Within this framing, 'non-compliance' with the proffered interventions – for instance, less than 50% of people prescribed statins still take them two years later (Jackevicius et al., 2002) – is 'a major problem in health care' (Vermeire et al., 2001), one for which solutions are sought by many researchers. Haynes et al (2008), for instance, review quantitative studies assessing interventions intended to overcome what Vermeire et al cast as 'barriers to

adherence'; in the context of statins and cardiovascular screening, McNaughton and Shucksmith's (2015) qualitative study seeks 'reasons for (non)compliance' with the risk-reducing interventions offered.

A countervailing narrative highlights the potential harms of the expansion of medicine's remit into the management of 'problems' such as cardiovascular risk, and frames this expansion as medicalisation. As well as harms that medical diagnoses and interventions can do to individuals, including the social and psychological effects of being assigned a liminal, 'at risk' status (Aronowitz, 2009, Scott et al., 2005), this narrative highlights wider concerns about governmental power and 'healthism' (Crawford, 1980), and reframes 'non-compliance' with medical advice as one possible product of a collection of self-regulation practices (Conrad, 1985). For instance, in a synthesis of qualitative evidence that highlights various concerns about harms of medication, Pound et al (2005) describe these concerns as contributing to 'resistance' to medication.

Britten et al (2015) offer a nuanced account of the positioning of potential patients or consumers in relation to the two competing framings of 'a pill for every ill', describing the way patients involved in evaluating a new drug for their own condition look closely at its possible benefits and consider a wide range of potential caveats, rather than simply demanding or resisting additional medication. By repositioning 'patients' as 'critical reflexive agents' (Williams and Calnan, 1996), such accounts situate themselves within a literature on pharmaceuticalisation which foregrounds the agency of potential pill-takers. This emphasis is developed by Dew et al's (2015) move away from focusing on medication as an object to be accepted or rejected, instead examining moral evaluations of medication practices.

Adopting this focus on the practice of pill-taking (rather than on the pills themselves), this article considers the morally-infused identity work involved in one health decision: deciding whether to take statins. A substantial body of research examines statin decisions, documenting understandings of cholesterol (Sachs, 1996, Polak, 2016) and risk (Crimson et al., 2007, Farrimond et al., 2010) and the way these get used in decision-making (Gale et al., 2011, Polak and Green, 2015b); but neither these nor more general accounts of resistance to medication or barriers to adherence seem adequate to explain why Smeeth and Hemingway (2012) find the 'pill for every ill' scenario inherently '*unattractive*'. An alternative explanation for their widely shared distaste centres on the identity potentially conferred by the practice of pill-taking. Eborall and Will's (2011) analysis of decisions about aspirin

highlights the difference between explanations centred on the pills and their effects, and explanations centred on pill-taking as a practice. The authors attribute ‘dislike of taking pills’ to the standardly-reported range of concerns about the medication itself (Pound et al., 2005), which they describe as mitigated by the reassuring familiarity of aspirin and balanced against its perceived benefits; they then explicitly distinguish this pill-centred ‘dislike’ from the wish to ‘avoid being seen as a “pill-popper”’. This identity management is central to the account presented here.

‘Identity work’ has long been a topic of analysis in studying the way people accommodate their chronic illnesses within a presentable biography (Radley, 1989). Resisting medication is often portrayed as a way of resisting an illness label; concerning asthma, for instance, Adams, Pill and Jones (1997) summarise an extensive literature (dating back to Goffman’s work on stigma) in their account of the work people do to avoid making their illness visible by using medication. In the same way, people might resist taking statins in order to avoid identifying themselves as having heart disease, and Farrimond et al (2010) found that even ‘being high risk’ was an identity that their participants worked to minimise or normalise. However, this account does not solve the puzzle highlighted here: people who comfortably talk about their health problems and describe taking lots of pills emphasise, like Eborall and Will’s participants, that they are ‘not pill-takers’. This article explores the way pill-taking constitutes a direct threat to a presentable identity, not just a threat mediated by spoiling a ‘healthy’ status: there is something inherently ‘wrong’ with being a pill-taker in general and a statin-taker in particular.

Methods

Data were generated by interviewing 34 people who had been offered a statin: participants (aged 53–87; 12 women; occupations including cleaner and company director) were recruited and interviewed face-to-face in community settings in East Anglia between 2011 and 2013. The choice to use non-clinical settings reflected the perception that decisions about long-term medication are distributed, involving multiple interactions rather than being enacted within clinical encounters (Rapley, 2008). An unforeseen advantage of conducting interviews at home was that twenty-two participants were interviewed with their partner. As discussed by Polak and Green (2015a), these couple interviews offered additional analytic purchase; they functioned as a hybrid between focus groups and individual interviews, facilitating exploration of the tensions negotiated and tacit resources drawn on in the process of making

decisions, while still providing a setting private enough to allow participants to discuss sensitive topics.

Invitations to participate were made through community groups such as lunch clubs and an exercise class, and snowballing from initial participants. All interviews were conducted by the author, recorded, and transcribed verbatim. They were semi-structured, using a brief topic guide which included questions on participants' health and how they looked after it, where their knowledge about health came from, and their decisions about and use of medication in general and statins in particular. Ethical approval was obtained from the author's institution. All names in this paper are pseudonyms, and identifying material has been removed.

All participants identified themselves as 'well' when interviewed, although 16 had previously suffered a heart problem requiring urgent hospital admission (some did not specify the precise diagnosis, or expressed uncertainty about it); all these are referred to here as having had a heart attack. The analysis presented here does not compare people who had had heart attacks with people who had not; despite the clear biomedical distinction between these two groups, offered 'secondary' and 'primary prevention' respectively, Lytsy, Burell and Westerling (2010) found no difference between them regarding statin decisions. Polak (2016) supports this finding, highlighting the slippery distinction between 'prevention' and 'treatment' in accounts of medication decisions, and the functional similarity between cholesterol and heart problems as reasons for taking statins.

Almost all participants took regular medication. In the analysis presented, differences between such medications are not highlighted except in the section specifically concerning statins, where a comparison is made between the 23 participants taking statins and participants not taking them.

Analysis employed elements of a grounded theory approach, in an iterative process whose rigour was increased by regular discussion with colleagues about coding decisions and analytic direction. The data were used as a source of insight not into what people thought or did, but into the discursive frameworks which make sense of what is said, an analytic approach exemplified by Green et al (2003) in their use of group interview data to illuminate the 'rules of thumb' governing food choices, rather than the choices themselves; and by Eborall and Will's (2011) exploration of the clashes of norms which inform decisions about preventive medication. Radley and Billig (1996) advocate this focus on participants' accounts, rather than on their health beliefs, as a way to study the way a presentable identity

is constituted. Here, participants' accounts of their medication practices are cast as work they do to present themselves in a way they are comfortable with, and specifically are used to explain why presenting oneself as a 'pill-taker' is uncomfortable.

Findings

Too many pills: what is wrong with 'being a pill-taker'?

Larry, taking statins since his heart attack, exemplifies a paradox presented by many interviewees: although he describes taking four different pills every day, he says '*I have never been, really a pill-taker*'. His statement seems to reply to an unspoken accusation that he takes too many pills; the implication is that pill-taking is bad. This implication is supported by the finding that taking lots of pills is almost always presented as something done by other people; when talking about themselves, most people emphasise how few pills they take. The following exchange between Violet and her husband Jim exemplifies this: Jim responds with a defensive '*but –*' to Violet's story about some (other, unspecified) people taking too many pills for too long, pills they may not '*need*'. He is asking Violet to reassure him by agreeing that he is different from those others because he has reduced the number of pills steeply since coming out of hospital.

Interviewer: Why would you say fewer pills is better?

Violet: Well because sometimes you don't need all the medication....

Jim: but the things I am on are just the two little pills in the morning I take now, don't I?

Talking more generally about her antipathy to pills, Gill explicitly references the trope that 'a pill for every ill' is a bad idea:

Gill: Our lives are, run by tablets now....whatever's wrong with you, you take a tablet

Interviewer: and is that a good thing?

Gill: no because they don't get to the root of the problem....the last 20 years now, everything is pills

This anti-pill trope is prevalent in the data. Its pervasiveness is perhaps illustrated by the fact that it is unthinkable that Yvonne would say she does '*like taking drugs*', at least in this context:

Yvonne: I don't like taking drugs

Interviewer: Can you say why that is?

Yvonne: Because it's abnormal to the body

Gill's and Yvonne's mentions of concerns that taking pills is '*abnormal to the body*', or that '*they don't get to the root of the problem*', could be construed as indicating perceptions of pills as inherently undesirable objects, and thus as echoing the broad findings of much qualitative research on accounts of perceptions of medication. But these concerns are mentioned only when prompted by the interviewer's questions, suggesting instead that their primary role in these accounts is to rationalise a morally-coloured distaste not for the pills themselves but for the practice of pill-taking.

Distaste for pill-taking is indirectly visible in an extract from Kathy's interview. Kathy is an exception to the general rule that taking lots of pills is something other people are described as doing, not oneself; she speaks at some length about the complexity of her pill regime, which involves taking '*on average about 25 tablets a day*':

Kathy: When people say I can do without them, I do wonder if there is as much wrong with them as they say there is, because most of the people I know who take them really really need them....They do react badly if they don't [take them]

Two features of this excerpt provide insight into the moral work of pill-taking. First, Kathy presents her account framed in a defensive reply to what '*people say*'; she is one of the people who '*do react badly*' if she doesn't take them, the '*do*' emphasising the defiant tone of her statement. Second, her switch within this statement from the first to the third person, from people suggesting that she herself '*can do without*' pills, to this applying to '*people I know*', can be seen as a device for talking about something a bit embarrassing or shameful; Kathy's use of this device suggests that pill-taking is inherently a bad thing, uncomfortable to admit to. The way she protects herself against the discomfort of this admission is by emphasising that she '*really really need[s]*' her pills, and so is different from someone who takes pills she does not need; 'need' is presented as an impregnable defence against the tacit accusation that she takes too many pills.

Exactly what constitutes need is often hard to pin down; Don and Mary's exchange illustrates a common circularity in the data between the definition of need and the definition of '*a condition*':

Don: If you can keep yourself healthy....then why should you take tablets, for anything at all?

Mary: But if you have a condition you would –

Don: Well if you have a condition well that's right....we've had more than one.... episode, haven't we, Mary, of where you needed medication. So that to me is a different sort of situation, to the one which I'm in, which is just....maintaining a healthy body.

Like Don, many interviewees speak of 'need' as a binary entity which is either present or absent, and the condition for which pills are needed is often left unspecified, although explanations like Kathy's '*they do react badly if they don't [take them]*' are sometimes added. However, such explanations are not offered for taking statins; as one participant explains, statins '*are not immediate effect type of pills*'. Instead, most present themselves as needing statins for two reasons which often co-exist: first, they need to treat their cholesterol level, which is thus reified as a condition, and second, a doctor has said they need to take them.

Debbie: They tested your cholesterol....

Keith:....and they said it was about 6.9 and they put me on [statins]

Larry: He pointed his finger at me and he said 'If you want to live a normal life you take the tablets and you'll live to be an old man....Don't take the tablets and who knows what will happen'. So, I have always taken my tablets

Crucially, neither Keith nor Larry presents himself as choosing to take statins; instead both imply that they need to take them. Rather than seeking to pin down the meaning of 'need', considering its function in these accounts of medication-taking gives useful analytic purchase: participants use 'need' to protect them from the unwanted 'pill-taker' label, and what constitutes 'need' in this data is absence of choice. In the next excerpts, the distinction between needing to take pills and choosing to take them is indicated by Mike's use of the word '*consumers*', and by Ron's mention of '*affecting*' pills. These terms serve to emphasise that the speakers themselves are not people who choose to take pills:

Eileen: We never take painkillers do we?

Mike: No.

Eileen: I would have to be really, poorly you know.

Mike: We have taken paracetamol a couple of times, but we are not really regular consumers are we

Ron: I have never really taken pills have I...I've always been quite sporty....I have never affected pills

The context in which Ron makes his remarks is illuminating: he is responding to an invitation to tell the story of how he came to be taking pills, and most of his long answer describes his many sporting achievements in the past. By answering a question about pill-taking with a description of himself as a 'sporty' person, he indicates a tacit assumption that being the kind of person who 'affect[s]' (or chooses) pills is the antithesis of being 'sporty'. Thus accounts of pill-taking articulate with concerns about identity: Ron's identity as an admirably sporty person is not threatened by the fact that he now takes several kinds of pill, because he takes them only because he needs them. His story, like Eileen and Mike's exchange, implies that some (unspecified, other) people choose to take pills they do not need; 'needing' pills and 'choosing' to take them are presented as mutually exclusive. Thus talk about need can be seen as a shield against an unwanted identity, helping someone who takes pills to avoid presenting herself as a pill-taker; she only takes pills because she needs to, so cannot be accused of taking too many. However, this highlights a challenge: judging how many pills is 'just right' rests on a complex process of evaluation.

Sensible pill-taking: the challenge of calibration

In this data, health practices such as pill-taking are frequently evaluated by comparisons with largely-tacit norms specifying, for instance, the right amount of concern about health.

Barbara illustrates this, in her morally-coloured account of trying to avoid being 'stupid' and 'over' reacting to 'little' pains:

Barbara: You can imagine such awful things that a little ache and pain, and I try not to be stupid about it...I mean, not, not to get , over worked-up about everything

Several interviewees indicate that calibrating just how worked-up one ought to get is tricky, and often involves balancing competing norms. Like most participants, for instance, Neil begins by making it clear that he tries not to take pills:

Neil: I avoid pills, I wouldn't take pills for a headache not unless I had to

Then later he expands on this in a way which helps explain what he means by ‘*I had to*’, after describing having realised after his heart attack that for a while he had been ignoring pains which were probably early warnings of trouble. The next excerpt highlights the tension between responding to ‘*continuous... pain*’ and not responding to ‘*a little niggle*’; Neil contrasts his own prudent identity with the unacceptable one of being ‘*just that way inclined*’:

Neil: I have learnt not to put up with something....if you’ve got a pain and it’s continuous, I don’t mean a little niggle because I’ve got a mother-in-law like that, she will phone up and go for anything, she’s just that way inclined

This tension is further illustrated in an exchange where Claire and Walter work to reach agreement about the right time to call an ambulance if she gets chest pain after her recent heart attack. Here a three-way balance has to be struck, involving obeying doctors’ advice as well as stoicism and sensible caution:

Claire: We called the ambulance out twice and it goes against my grain that I don’t want to be you know like Peter and the Wolf.

Walter: But you don’t get a choice if you are in pain you cannot question that, because you don’t get a second chance.

Claire: Well it is that little puffer if you take it twice you need to call and I am embarrassed to ring up, you know, I just think that I am not ill enough.

Doctors’ advice is the subject of a further tension to be negotiated, between accepting it sensibly and obeying it unquestioningly. Many interviewees imply that if a doctor says you need the pills then it is ‘*silly*’ not to take them:

Ann: A friend some years ago. ...I thought ‘oh you silly woman, you’ve been prescribed them, you should stick to it’, but, she gave up

Similarly, the way Frank speaks about being ‘*a sort of person*’ who heeds authority suggests he views this as a positive facet of his identity, rather than an unfortunate weakness:

Frank: I’m not a sort of person who gives up on prescriptions – if somebody’s told me I ought to take something, I take it

But deference to medical authority can be evaluated differently: Fiona, for instance, says that it is only thanks to luck that her husband Ron’s obedience, here framed as rather overly deferential, has not resulted in ‘*any nasty experiences*’.

Fiona: Ron does accept things like that. He thinks doctors are gods and if they say something he'll do it, and, but you've been lucky, because you've never had any, any nasty experiences with pills have you?

Thus identity shapes and is shaped by health practices such as responding to doctors' advice, and these practices are themselves informed by a collection of often-conflicting moral discourses.

The alternative to over-deference to doctors' orders is to collect information from other sources. However, this too requires calibration to avoid doing either too much or too little. Two contrasting excerpts illustrate this: Fiona criticises herself for not seeking information about statins, while Colin defends himself against an implicit charge of excessive information seeking, distinguishing the way he '*sometimes take[s] an interest*' from 'hypochondria'.

Fiona: I must admit it was very bad of me because I didn't really look them up to see what they were, you know

Colin: I probably read it somewhere

Interviewer: So you...read a bit about such things

Colin: I don't – I'm not a hypochondriac, but if – I sometimes take an interest in these things

Collecting too much information thus risks earning the undesirable label of 'hypochondriac'. Indeed, several interviewees talk about too much information as liable to cause hypochondria, producing imaginary ailments. The list of potential side-effects in the pill packet was often mentioned as particularly likely to have this effect:

Eileen: If you read all the side effects, you wouldn't take them.

Mike: Well that's right. There are so many side effects, you know, you would be coughing and scratching!

Eileen: Pages like that, I don't know, we don't read them.

Claire and Walter, too, describe throwing away these information leaflets, because, as Walter says, '*you can bog yourself down can't you with the information*'. To emphasise that throwing away the leaflet is a sensible precaution against the possible bad effects of reading it, they tell the story of a relative: she did not take this precaution, but instead allowed herself

to be persuaded by the leaflets that pills were giving her side effects, thus depriving herself of the benefits she would have gained from taking them:

Claire: She read all the leaflets, not to find out what it would do good for you, but the side effects, you see.

Walter: That was her main priority, side effects...

Claire: and she would say it doesn't suit me, tried it a couple of times and –

Walter: – that was it, bang.

Claire:....obviously her health declined.

Thus gathering too much information may lead someone to take fewer pills than she needs, as well as (in the standard picture of a hypochondriac) leading him to take too many pills because of too much concern about his health, as Larry describes his father doing:

Larry: [He] was on something like 22 tablets a day....but he was a hypochondriac

Concern about one's health is the subject of another tricky calibration process. Many people reference general knowledge about healthy eating, presenting themselves as careful and hence responsible (doing what 'you have to'), as Don does:

Don: I wouldn't, have cakes, and so on, or a lot of pastry...sugar, it's hidden in just about everything, isn't it?...you have to be so, so careful

But taking too much care is 'faddy', as both Bill and Peter suggest in these extracts:

Bill: I think people get faddy, they find something like they've got to drink 2 litres of water a day

Peter: You can't spend your life self-analysing...You can't become paranoid, because if you do it will dominate your whole life, and my life will not be dominated

As well as marking one as faddy or paranoid, adopting good health behaviour is sometimes presented as being in tension with the requirement to enjoy life; Violet indicates an awareness of the need to balance these two rival imperatives:

Violet: Well we eat lots of vegetables because we have got the allotment, don't we. Mind, Jim has got quite a sweet tooth, he likes his chocolate. We've all got vices....I don't believe really that as you get older that you can't have some of the things that you like....You've got to have some joys in life.

Contextual factors like age can modify the way a ‘just right’ level of pill-taking gets determined; different participants use differing yardsticks to assess the number of pills they take. This difference is visible in the contrast between the anti-pills stance indicated by most participants and the welcoming approval of pills by just a few. These few are mostly among the oldest participants, such as Ann: describing a group of friends of her age cheerfully comparing notes about their many pills over coffee, she says the pills ‘*keep us going*’; needing pills is presented as normal at her age. Chris is younger than Ann, but has already reached an age at which serious illness is normal in his family, and has outlived several colleagues:

Yvonne: A lot of your colleagues sort of flaked out in their late fifties.

Chris: Oh blimey there was five of us... and we were all the same age funny enough... You know I am the only one left.

Like Ann, he shifts the balance towards the acceptability of pill-taking, saying that pills ‘*keep [him] alive*’ and explicitly casting them as a benefit of medical progress:

Chris: It’s drugs that keep us alive now....because both my parents, they both died in their 70’s....they had heart problems, but of course they didn’t have the medicine....

Both Ann and Chris seem comfortable identifying themselves as people who rely on pills, indicating no concern that they might be accused of taking too many. Chris’ lack of discomfort illustrates that age is itself calibrated not only chronologically but also through comparisons with other people like oneself. In this way, Chris implicitly presents himself as old enough to need lots of pills; hence pill-taking does not threaten his identity.

These interviewees thus work to present themselves as taking just the right number of pills, a number defined by a complex set of calibrations in which several tensions are inextricably entangled: the task of making just the right amount of effort to regulate one’s health involves collecting the right amount of information about one’s pills, and paying the right amount of heed to doctors’ advice and to information about healthy behaviours. Paying too much attention to one’s health and health behaviour, or reading too much about one’s condition and treatment, makes one liable to be labelled as a hypochondriac, but paying too little attention is negligent. Heeding doctors’ advice (for example, advice to take pills) articulates with both self-regulation and information gathering: one aspect of self-regulation is deciding whether to follow doctors’ advice unquestioningly, or whether to check it against other sources of

information. These densely articulating and often conflicting moral imperatives inform medication decisions; people have to negotiate a way through the tangle in order to distinguish between their own necessary, sensible pill-taking and the way other people behave.

People who take pills are so successful at presenting themselves as ‘not pill-takers’ that tensions between these two identities never surface in the data. Indeed, participants within a single interview draw on discourses both of the rejection of pill-taking and of the necessity for it. For instance Yvonne and her husband Chris, who both take several pills each day, move without apparent discomfort between her comment that ‘*I don’t like taking drugs*’ and his ‘*It’s drugs that keep us alive now*’. The potential contrast between these two comments is a component of the broader tension between the competing tropes of rejecting medicalisation and welcoming medical progress; Gill’s disapproving statement ‘*now, whatever’s wrong with you, you take a tablet*’ comes minutes before she echoes her husband’s enthusiasm about the heart treatment which they say has kept him alive beyond his biblically-defined span:

*Simon: I mean I’m 72 and each day I wake up, it’s a bonus really, is how I look at it—
Gill: three-score year and ten*

To these participants, the difference between taking pills which keep you alive and indulging in unnecessary pill-taking goes without saying; but considerable work is needed to demonstrate that their own medication practices are ‘just right’.

Needing pills that you ought not to need: the special case of statins and heart problems

Statins are one of a small group of drugs which are seen as dealing with a problem which could be also dealt with (or even avoided) by ‘good behaviour’; it is widely-shared common knowledge that you can keep your heart healthy by exercising more and eating less. Violet is one of many interviewees who reference this knowledge, talking here about the ways (other) people deal with concern about their cholesterol level; she does not take statins herself: “*Given the option of a pill or diet I think people will take the pill.*”. Violet’s account of a choice between pills and diet highlights the particular accusation which can be levelled against people who take statins: taking the pills can get cast as a ‘*lazy*’ or ‘*easier*’ option. For a small minority of participants, this is acknowledged as an incentive for their own decision to take statins, as Jim and Geoff suggest:

Jim: I just eat what she puts in front of me you know [laughs]. I eat what I want and the statins do the rest I suppose. It's a lazy attitude actually isn't it

Geoff: It's a damn sight easier [taking statins]....than running 5 miles a day and only eating vegetables

However, most people who explicitly frame 'pill or diet' as alternative ways of addressing health concerns have declined statins. They present this decision as choosing the 'virtuous' option instead of the pills:

Ed: I will do regular exercise, regular shopping at the farmers' market, regular cooking for myself....if I can get into those regular habits, then I hope I can avoid getting into the regular habit of taking....pills

This seems a simple statement of Ed's preference, but can be recognised as morally-loaded in the light of background knowledge that exercise and eating in certain ways is widely regarded as good behaviour.

In contrast, very few statin-takers present pills as an alternative to healthy 'habits'; indeed many cite their healthy habits as the reason for their current good health. Larry (who takes statins) does this, in an account very like Ed's:

Larry: I used to go to the gym regular, I have a bike which I use a lot to go shopping and things like that...so I am quite healthy as it goes

Don makes this moral colour even more visible; he talks of 'just....taking care' despite presenting himself earlier in the interview as needing (and taking) statins:

Don: It's just a matter of watching, what you eat, and taking care...if you do not need these things [pills] then do not take them... if you can keep yourself healthy, in terms of.... exercise, and a good...balanced diet....then everything should work ok, shouldn't it?

Don's 'everything should work ok' suggests that good health behaviour deserves the reward of good health, an idea highlighted by the anger Peter expresses about having a heart attack in spite of his 'healthy lifestyle':

Peter: There was all sorts of things that we didn't do, so when I had a heart attack I was really annoyed because....we were not doing the bad things anyway, and we were

eating lots of fruit and....vegetables and, all those things you are supposed to do for a healthy lifestyle, and I still had a heart attack

Thus almost everyone interviewed here emphasises their own good behaviour, whether or not they take statins, as Peter does. This linkage of health and behaviour inevitably implies that, at least in the context of heart disease, an illness is not just unpleasant in itself; it may also be an unwelcome indication of failure to behave well enough. This implication helps explain the discomfort or reluctance with which people speak about pill-taking even when it is clearly 'needed' because of an unequivocally-diagnosed medical problem. In the next excerpt Vic, another statin-taker, makes efforts to mitigate this discomfort, both by playing down the size of the problem (he hesitates before mentioning his heart attack and then refers to it as '*the little scare*') and by emphasising his fitness and his virtuous gym attendance:

Vic: Dr Brown at our doctors....reckons that I am probably the fittest person on their books of my age....I am marginally fitter now than I was before I had the, if you like the little scare...because I go to the cardio gym....but when I compare myself to an awful lot of other people....they haven't learnt by it and are not doing anything in comparison.

These excerpts highlight the strong moral discourse about health promotion and self-regulation that makes sense of Smeeth and Hemingway's (2012) distaste for using tablets to '*mitigate against unhealthy lifestyles*'; this discourse presents a major obstacle to legitimating a decision to take statins, and helps legitimate a decision to decline them, as indicated by several of those interviewees who are not taking statins. Almost all those who are taking statins work within their interviews to circumvent this obstacle so as to present an acceptable identity, emphasising their virtuous adoption of healthy behaviours (alongside their need to take statins and other pills) and thus distinguishing themselves from other people who are lazy pill-takers. With statins, as with medication in general, 'need' serves to legitimate pill-taking, whereas choosing to take pills is something almost nobody describes themselves as doing: Geoff is the only interviewee who explicitly presents virtuous health behaviours as an option which he has rejected, instead opting for statins, which he describes as '*a light punishment for the sin of living badly*'. Unsurprisingly, few other interviewees present themselves as sinners.

Discussion

These findings describe the moral discourses used to legitimate taking medication in general and statins in particular. In foregrounding the way tensions between such discourses are negotiated, this article builds on Dew et al's (2015) discussion of the moral discourses which inform the relationship between pharmaceuticals and identity and hence shape medication practices. However, examining how people come to take (or to decline) statins requires a further analytic move, situating these medication practices within a broader web of health practices informed by the widely-shared perception that statins are taken 'to mitigate against unhealthy lifestyles'. Because of this perception, statin-takers have to defend themselves against two threats to a presentable identity: they stand tacitly accused not only of 'being pill-takers' but also of having 'unhealthy lifestyles'.

Both these accusations imply a choice to take statins, so it is unsurprising that having 'no choice' is a particularly salient feature in statin-takers' accounts in these data. Describing some of the clashes of norms negotiated by people considering aspirin, Eborall and Will (2011) highlight the way 'need' confers legitimacy on pill-taking. In these data, too, those who take pills emphasise that they need them; 'a pill-taker' is someone who takes more pills than they 'really need'. Participants present 'need' as a binary quality, the antithesis of 'choice': almost nobody describes themselves as choosing to take pills, and several people state explicitly that they have no choice but to take them. This finding, that absence of choice is used to legitimate medication decisions, may help explain the low uptake reported by Will and Weiner (2015) in their study of over-the-counter statins. One plausible explanation of their finding that statins 'don't sell' is that choosing to go and buy pills for oneself, as opposed to obeying doctors' orders, threatens one of the main defences participants use against the 'pill-taker' accusation: one 'needs' pills if a doctor says so. This defence often articulates with 'having a condition', a status (discussed by Polak (2016)) whose circular relationship with 'needing medication' is implicit throughout these data.

Yet while 'need' is a necessary constituent of legitimacy, it is not a sufficient one; some 'conditions' are not morally neutral, for two reasons: either the elevation of a problem to 'condition' status may be contested, or the condition may be of a kind that one ought to have avoided getting. Pain is an example of a problem whose legitimization of pill-taking is fragile – in these interviews, only other people take pills for 'a little niggle'. Another example of fragile legitimacy concerns insomnia; Gabe et al (2015) describe the morally-charged negotiations involved in talk about sleeping pills. Like in the data here, Gabe and colleagues found 'need' was constituted either by having problems which functioned as a condition (in

participants they classify as ‘deserving’ pill-takers), or by ‘compliance’ with medical advice. This need was invoked to legitimate pill-taking, and balanced against concerns about side-effects or addiction. In a group Gabe et al call ‘sinful’ pill-users, however, the fragility of insomnia as a legitimating condition is highlighted: without medical advice, its status falls below the threshold for legitimation, rendering pill-taking ‘naughty’.

The threat to identity against which our participants defend themselves is different: those taking pills state unequivocally that they ‘really need’ them. The weakness in the legitimating process is not in the framing of cholesterol and heart problems as conditions, but in the stigma attached to these particular conditions. Crawford’s (1994) reflections on the cultural meanings of AIDS help to understand this stigma. Although heart disease is not infectious, it shares with AIDS the moral opprobrium derived from perceptions about lack of ‘self-control’; elsewhere (1980) Crawford describes this as a component of healthism: ‘failure to maintain health is ascribed to ... a failure of will’. The number of health problems liable to incur such blame is increasing as more are recognised as potentially ‘caused by lifestyle factors’; hence heart disease and statins constitute a useful case study, a context in which the anti-pill trope informs a preference for declining medication in favour of using will-power to make health-maintaining ‘lifestyle choices’.

The health promotion discourse this reflects is surfaced here by participants’ frequent references to knowledge about cholesterol, diet and exercise, and by their morally-coloured accounts of health practices. This discourse incorporates widespread knowledge linking coronary candidacy to ‘*unhealthy lifestyles*’ (Angus et al., 2005, Davison et al., 1991, Weiner, 2009), together with values concerning individual responsibility and autonomy. Having this knowledge (enough but not too much) is a constituent of constructing oneself as a responsible citizen, and as one has the autonomy to act upon it, it follows that someone needing statins is particularly likely to be accused of being ignorant, lazy or irresponsible. Autonomy can be seen as the obverse of dependency (on medical advice, for instance), but this binary framing fails to represent the complex calibration process seen in participants’ accounts of their health practices, where they work to resolve a tension between stubborn rejection and passive acceptance of doctors’ advice. This work exemplifies the wider enterprise of which it is a constituent, the enterprise of handling two rival tropes that inform medication practices, one framing ‘a pill for every ill’ as desirable medical progress while the other frames it as undesirable medicalisation. Rather than amalgamating competing tropes or balancing them against one another, this calibration work serves to ‘allow people to move between different

kinds of talk relatively smoothly', as Will and Weiner (2014) describe in the context of talk about 'healthy living'. Medication practices are thus informed and legitimated by a multiplicity of discourses, rather than a single unified one.

As well as informing participants' accounts, these multiple discourses are also visible in research and commentary about medication-taking, blurring the boundary between stances traditionally associated with either the biomedical or the social science community. In the biomedical literature, growing interest in 'overdiagnosis' or 'too much medicine' (Moynihan, 2012) in recent years shows that an anti-medicalisation discourse is gaining ground; patient empowerment and choice are unquestioned goals in health policies and clinical training; and Smeeth and Hemingway's (2012) comment voices an increasingly prevalent anti-pharmaceuticalisation trope. Within the social science literature, this trope is sometimes implicitly in tension with a broader anti-medicalisation discourse that highlights the medicalising effect of individual responsabilisation for health and identifies healthism as 'a form of medicalisation' (Crawford, 1980). The case of statins is used here to problematise that tension, highlighting the articulation between critiques of 'dependency' on doctors and pills (Crimson et al., 2007) and the growing valorisation of the autonomous, self-determining individual characterised by Crawford (1994) as a 'bourgeois ideal'. This study suggests that those offered statins negotiate a complex tangle of conflicting norms which is perhaps too seldom considered by those who advise or study them.

Conclusion

Pill-taking can be an obstacle to presenting an acceptable identity. To legitimate taking medication, people present themselves as taking pills because they need them; it would be irresponsible or stupid not to take pills one needs. Needing statins, however, constitutes an extra threat to the enactment of moral adequacy, because of the well-recognised health promotion discourse which suggests that a healthy lifestyle can reduce cholesterol or prevent heart problems. Those who reject statins invoke this discourse. More surprisingly, statin-takers indicate acceptance of it, too; most emphasise that they need statins despite their own virtuous lifestyle, rather than through choice. Their accounts reference both possible framings of 'a pill for every ill': by emphasising that pills '*keep us alive*' one avoids presenting oneself as '*a pill-taker*'.

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References

- ADAMS, S., PILL, R. & JONES, A. 1997. Medication, chronic illness and identity: The perspective of people with asthma. *Soc Sci Med*, 45, 189-201.
- ANGUS, J., EVANS, S., LAPUM, J., RUKHOLM, E., ST ONGE, R., NOLAN, R. & MICHEL, I. 2005. "Sneaky disease": the body and health knowledge for people at risk for coronary heart disease in Ontario, Canada. *Soc Sci Med*, 60, 2117-28.
- ARMSTRONG, D. 1995. The rise of surveillance medicine. *Sociol Health Illn*, 17, 393-404.
- ARONOWITZ, R. 2009. The Converged Experience of Risk and Disease. *Milbank Quarterly*, Volume 87, 417-442.
- BRITTEN, N., DENFORD, S., HARRIS-GOLESWORTHY, F., JIBSON, S., PYART, N. & STEIN, K. 2015. Patient involvement in drug licensing: A case study. *Soc Sci Med*, 131, 289-296.
- CONRAD, P. 1985. The meaning of medications: another look at compliance *Soc Sci Med*, 20, 29-37.
- CRAWFORD, R. 1980. Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10, 365-368.
- CRAWFORD, R. 1994. The boundaries of the self and the unhealthy other: Reflections on health, culture and AIDS. *Soc Sci Med*, 38, 1347-1365.
- CRINSON, I., SHAW, A., DURRANT, R., DE LUSIGNAN, S. & WILLIAMS, B. 2007. Coronary heart disease and the management of risk: Patient perspectives of outcomes associated with the clinical implementation of the National Service Framework targets. *Health, Risk & Society*, 9, 359-373.
- DAVISON, C., DAVEY SMITH, G. & FRANKEL, S. 1991. Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education *Sociology of Health and Illness*, 13.
- DEW, K., NORRIS, P., GABE, J., CHAMBERLAIN, K. & HODGETTS, D. 2015. Moral discourses and pharmaceuticalised governance in households. *Soc Sci Med*, 131, 272-279.
- EBORALL, H. & WILL, C. M. 2011. 'Prevention is better than cure, but...': Preventive medication as a risk to ordinariness? *Health Risk Soc*, 13, 653-668.

- FARRIMOND, H., SAUKKO, P. M., QURESHI, N. & EVANS, P. H. 2010. Making sense of being at 'high risk' of coronary heart disease within primary prevention. *Psychol Health*, 25, 289-304.
- GABE, J., COVENEY, C. & WILLIAMS, S. 2015. Prescriptions and proscriptions: moralising sleep medicines. *Sociology of Health and Illness*.
- GALE, N. K., GREENFIELD, S., GILL, P., GUTRIDGE, K. & MARSHALL, T. 2011. Patient and general practitioner attitudes to taking medication to prevent cardiovascular disease after receiving detailed information on risks and benefits of treatment: a qualitative study. *BMC Fam Pract*, 12, 59.
- GREEN, J. M., DRAPER, A. K. & DOWLER, E. A. 2003. Short cuts to safety: risk and 'rules of thumb' in accounts of food choice. *Health Risk Soc*, 5, 33-52.
- HAYNES, R. B., ACKLOO, E., SAHOTA, N., MCDONALD HEATHER, P. & YAO, X. 2008. Interventions for enhancing medication adherence. *Cochrane Database of Systematic Reviews* [Online].
- HUXLEY, A. 1932. *Brave New World*.
- JACKEVICIUS, C. A., MAMDANI, M. & TU, J. V. 2002. Adherence with statin therapy in elderly patients with and without acute coronary syndromes. *JAMA*, 288, 462-467.
- LYTSY, P., BURELL, G. & WESTERLING, R. 2010. Views on Treatment Necessity, Harm, and Benefits in Patients Using Statins. *Medical Decision Making*, 30, 594-609.
- MCNAUGHTON, R. J. & SHUCKSMITH, J. 2015. Reasons for (non)compliance with intervention following identification of 'high-risk' status in the NHS Health Check programme. *J Public Health (Oxf)*, 37, 218-225.
- MIHAYLOVA, B. & AL, E. 2012. The effects of lowering LDL cholesterol with statin therapy in people at low risk of vascular disease: meta-analysis of individual data from 27 randomised trials (Cholesterol Treatment Trialists' Collaborators). *The Lancet*, 380, 581-590.
- MOYNIHAN, R. 2012. Preventing overdiagnosis: how to stop harming the healthy. *BMJ*, BMJ 2012;344:e3502.
- NICE 2014. Lipid modification.
- PARISH, E., BLOOM, T. & GODLEE, F. 2015. Statins for people at low risk. *BMJ*, h3908, 351.
- POLAK, L. 2016. Current conditions or future risks: certainty and uncertainty in decisions about statins. *Health, Risk & Society*.
- POLAK, L. & GREEN, J. 2015a. Using Joint Interviews to Add Analytic Value. *Qualitative Health Research*.
- POLAK, L. & GREEN, J. 2015b. Using quantitative risk information in decisions about statins: a qualitative study in a community setting. *British Journal of General Practice*, 65, e264-e269.

- POUND, P., BRITTEN, N., MORGAN, M., YARDLEY, L., POPE, C., DAKER-WHITE, G. & CAMPBELL, R. 2005. Resisting medicines: a synthesis of qualitative studies of medicine taking. *Soc Sci Med*, 61, 133-55.
- RADLEY, A. 1989. Style, discourse and constraint in adjustment to chronic illness. *Sociology of Health and Illness*, 3, 230–52.
- RADLEY, A. & BILLIG, M. 1996. Accounts of health and illness: dilemmas and representations. *Sociology of Health and Illness*, 18, 220-240.
- RAPLEY, T. 2008. Distributed decision making: the anatomy of decisions-in-action. *Sociol Health Illn*, 30, 429-44.
- SACHS, L. 1996. Causality, responsibility and blame – core issues in the cultural construction and subtext of prevention. *Sociol Health Illn*, 18 632-652.
- SCOTT, S., PRIOR, L., WOOD, F. & GRAY, J. 2005. Repositioning the patient: the implications of being 'at risk'. *Soc Sci Med*, 60, 1869-79.
- SMEETH, L. & HEMINGWAY, H. 2012. Improving vascular health: are pills the answer? *BMJ*, 344, e3802.
- VERMEIRE, E., HEARNSHAW, H., VAN ROYEN, P. & DENEKENS, J. 2001. Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics*, 26, 331–342.
- WEINER, K. 2009. The tenacity of the coronary candidate: how people with familial hypercholesterolaemia construct raised cholesterol and coronary heart disease. *Health*, 13, 407-427.
- WILL, C. M. & WEINER, K. 2014. Sustained multiplicity in everyday cholesterol reduction: repertoires and practices in talk about 'healthy living'. *Sociology of Health and Illness*, 36, 291–304.
- WILL, C. M. & WEINER, K. 2015. The drugs don't sell: DIY heart health and the over-the-counter statin experience. *Soc Sci Med*, 131, 280-288.
- WILLIAMS, S. J. & CALNAN, M. 1996. The 'limits' of medicalization?: Modern medicine and the lay populace in 'late' modernity. *Soc Sci Med*, 42, 1609-1620.