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Conceptualizing risk

Three friends of ours in their late 40s were diagnosed not long ago with breast cancer. All 3 underwent lumpectomy; all had single axillary nodes that were estrogen-receptor positive. Premenopausal, they were offered chemotherapy and went through 4 months of profound fatigue, hair loss and occasional fever with leukopenia while keeping their terror largely hidden. They and their families and friends easily adopted the common language of cancer, describing the experience as a “fight” or “battle” in which there could be only one victor, themselves or the cancer.

But what exactly is the effectiveness of chemotherapy for breast cancer? Current guidelines¹ suggest that chemotherapy improves the 10-year survival rate for premenopausal women under age 50 from 63% to 69%. This difference in survival can be presented, as in the guidelines, as a 16% relative reduction in mortality (mortality rates of 31% v. 37%), a 9.5% improvement in relative survival (67% v. 63%), a 6.8% absolute improvement in 10-year survival, or the number of women (17) who must be treated to prevent 1 death over 10 years. But in all of these figures there is no suggestion of victor and vanquished. There are only probabilities that some would regard as dismal.

Our friends' treatment has been declared a success — in the face of compelling evidence that one among them may not survive the next 10 years. Such is the ideology of health care and the human need for hope. By all appearances, at least, these women have resumed their lives in the belief that they have “beaten” their cancer. In a similar way, patients who are compliant with treatment for hypertension, elevated lipid levels or some other risky condition usually believe — averages be damned — that the treatment works in *their* case despite the only marginal gains demonstrated in clinical trials. Patients do not typically consider treatment effects in terms of the ambiguities

of trial results so much as in terms of likely outcomes over which they hope to exert some control: “If I take the drug I'll be okay; if I don't I'll probably have another heart attack.”

Physicians play a role in perpetuating simplistic perceptions of benefit and risk. Two recent papers in the *Annals of Internal Medicine*^{2,3} draw attention to the language physicians use in presenting risk data to patients. Most physicians give these data not as raw numbers (absolute or relative risks) but as a boiled-down absolute intended to influence the patient's decision: “Unless you take this drug you'll have a recurrence.”⁴ And — leaving aside the difficulty of conveying the subtleties of risk in the limited time available during a patient visit — perhaps this is what many patients want. There is some evidence that many patients would rather defer to their physician's judgement when faced with treatment decisions.^{5,6}

At this journal we urge authors to present risk data both in terms of populations (absolute risk reductions and numbers needed to treat) and in terms of individuals (relative risk ratios). Practising physicians need this information so they can present a balanced view of treatment options to their patients. But how physicians actually communicate probabilistic information to patients will likely depend more on how the patient understands and values this information than on the data themselves.

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