Examining Personal Health Decisions

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The Affordable Care Act aims to boost health at the population level by making healthcare affordable and accessible to all. But, even with greater access to healthcare, many aspects of health ultimately rest on individual-level decision making. Two new research articles published in *Psychological Science*, a journal of the Association for Psychological Science, explore how people make health-related decisions, and how those decisions aren't always rational.

The first article reveals people's tendency to follow the status quo when making health-related decisions — even when the status quo is objectively worse. The second article shows that simply contemplating reasons for seeking or avoiding health test outcomes makes people more likely to follow up for their results, but only for conditions that are treatable.

Patient Inertia and the Status Quo Bias: When an Inferior Option Is Preferred

Gaurav Suri, Gal Sheppes, Carey Schwartz, & James J. Gross

Medical noncompliance — or failure to follow the doctor's orders — is estimated to increase healthcare costs in the US by $100 billion per year. Patients sometimes opt not to take medicines, for instance, because the side effects are unbearable or the dosing regimens are too complicated. But medical noncompliance may also stem from sheer inertia — the tendency to stay in the current state, even when that state is undesirable.

In a series of studies, Gaurav Suri and colleagues from Stanford and Tel Aviv Universities tested whether this status-quo bias could result in behavior that is detrimental, and whether such a bias could be lessened with minimal interventions.

In the first study, participants were told that the research would involve receiving electric shocks. One group was told that they were required to choose one of two options: They could press a button to stop the shock 10 seconds earlier, or press another button to keep the waiting time the same. As the researchers expected, most people opted to get the shock over with early.

In contrast, those participants who were told that they could press a time-decrease button if they wanted to were more likely to stick with the status quo: Only about 40% chose to push the button in order to shorten the trial.

The researchers saw similar results when they told participants that pressing a button would reduce the chance of shock by as much as 90%. Those participants who had to make a proactive choice to press the button opted to leave it untouched about half the time, even though it meant they had to withstand

shocks they themselves rated as highly undesirable.

These studies clearly demonstrate that, when faced with a choice that requires them to make a proactive decision, people often opt do nothing, even when actions that are easy to perform could noticeably improve their current state.

Interestingly, the researchers found that simply requiring participants to press the button on an early trial made them more likely to hit the button on later trials. Thus, while medical noncompliance may sometimes result from patient inaction, the researchers conclude that people may be capable of making productive choices about their health if given a nudge in the right direction.

Reducing Health-Information Avoidance Through Contemplation

Jennifer L. Howell & James A. Shepperd

Some studies of at-risk populations suggest that up to half of the people tested for HIV never return to the doctor's office to find out their test results. While many of these people may simply forget to return or deem the results unimportant, it is likely that a portion of people don't return because they don't *want* to know the results.

In three studies, Howell and Shepperd investigated whether prompting people to contemplate their reasons for seeking and avoiding the health information would make them more willing to receive their medical results.

Participants filled out a motives questionnaire intended to make them think thoroughly about the reasons underlying their decision to seek or avoid their results. Questions included: "Learning that I am at high risk for diabetes would be distressing," or "I would regret not learning my risk for diabetes."

All participants also filled out a diabetes risk calculator and received the opportunity to learn their risk. Those who filled out the motives questionnaire before deciding whether to learn their risk were more likely to choose to see their results than those who filled it out after deciding whether to learn their risk. The same trend emerged when participants generated their own reasons for seeking or avoiding their risk for cardiovascular disease. Together, these two studies suggest that prompting people to contemplate their reasons for seeking or avoiding health information makes them more likely to seek out information about their own health risks.

But it turns out that this effect was only applicable for conditions that are treatable. In the last experiment, some participants were told that TAA deficiency — a made-up condition — was treatable, and some were told it was not. Contemplation made participants more likely to seek out their test results when they thought the condition was treatable, but not when they thought it was an untreatable disease.

As medical treatments become more advanced, early detection and intervention will become increasingly important. Simply asking patients to contemplate the reasons they would seek or avoid their screening results may make them more likely to follow up with their doctor, thus reducing the public

health burden.