

Learn how to think irrationally

How do you **motivate** your patients?

LONDON – People make important medical choices based on emotion and justify their decisions with logic.

It's one of the most challenging principles for healthcare marketers and analytical people, like our clients, to understand. It's the reason why a patient will often not choose what an analytical person clearly sees as the "best option" or "best package". Irrational choices made by patients and customers can be frustrating, but it's not their fault. People are irrational because they're human, and their neural wetware are loaded up with hundreds of logic-defying heuristics and biases.

In my upcoming 1 hour seminar on "How to motivate your patients", I'll explain the most relevant biases and heuristics people use when making important medical decisions. Attending eye surgeons will learn how to consider these mental models in the context of their practices.

Most people think they're rational, but in many cases, they're not. This rationality gap is what behavioural economists call bounded rationality. In a perfect economic world, people make good decisions. However, limits of information, time, and abilities prevent people from seeking the best possible outcome.

One needn't look very far to see glaring examples of people choosing irrationally: the US Presidential Election and the Brexit result are two recent, large-scale examples of irrationality en masse.

A more pedestrian example is the Price - Quality Heuristic. The Price - Quality Heuristic is put into use when consumers interpret the price of something as being relatively low. Since they feel there must be something wrong with it, consumers may not buy it as much. On the other hand, if healthcare marketers set the price of something relatively higher than consumers expect, some customers buy it more.

This result flies in the face of the economic law of supply and demand



Medical choices are made based on emotion and justified with logic.

which suggests that the quantity demanded of a good goes up as the price goes down, and vice versa. So, what's going on?

Take the Red Wine Taste Test. In this test, researchers attached sensors to scan the brain activity of people tasting wine. Brain scans show that people enjoy expensive wine more. This happens whether the wine is truly high quality or not. People just have to believe it's more expensive, and then they'll like it more.

Another example of irrationality is the Ultimatum Game. Let's say I give you 100 pounds in 20-pound notes on the condition that you split it with your friend. You can offer your friend as little or as much of it as you like, but if they reject your offer, neither of you gets any money.

It turns out that when researchers offer this scenario to subjects, half of the respondents turn down the proposer's offer if it's 30% or less of the total. So neither of them win!

The fact is, human motivation is not always motivated solely by gain; it's also shaped by fairness, injustice, and even revenge.

The power of framing

Which would you prefer? A steak that is only 25 percent fat or 75 percent fat-free? It depends on your perspective, doesn't it? What's surprising to

people after they pick one or the other is that they are in fact the same thing.

Which raffle ticket would you buy, the one where 1/1000 is a winner or 999/1000 are losers?

Which government policy would you support? Improve our schools or raise our taxes?

This is the power of framing. If healthcare marketers can frame a proposal in such a way that it mirrors people's values, then they're on to a winner.

Psychological pricing (financing and .99 price point)

Which sounds cheaper? Laser eye surgery for \$3000, or \$1.64 per day over five years? It turns out they are both the same, but the latter sounds cheaper than a daily cup of coffee, doesn't it? Which looks like the higher quality laser eye surgery? Laser eye surgery for €4999.95 or €5000? Despite many people being fooled by .99p pricing, most people opt for the round number when looking for quality.

Nudge theory

Can we get children to eat healthier by rearranging food on shelving? What if we put all the sweets on the lower shelf, and all the empty carbs on the higher shelf, and put more nutritious options at eye-level? It turns out that when school cafeterias did that more

kids chose healthier options.

Risk v loss

Let's say I have three envelopes I can offer you: One envelope has £100 inside it, the other has £0, the only problem is that you don't know which one has the money. Instead, I can just give you an envelope with £50 right now, and you can avoid the choice, does that sound better? Surprisingly, many choose the latter option of the sure thing (the £50 right now) even though they would have lost nothing if they took a chance between the envelopes, and had a 50% chance of doubling their gains. Your choice suggests whether you are risk-averse or risk-neutral. It turns out; most people are risk-averse, even when the risks are 0%.

Let's say I flip a coin, if it lands heads you get £100, if it lands tails you pay me £50. Who wants to play? Again, I'm astounded that many people won't take me on that game because they loathe to part with the £50 if they lose. But they have a 50% chance of winning £100!

People want to avoid losing, more than they want to win

Researchers have proven this principle in grocery stores. Why does Sainsbury's charge 5p for shopping bags instead of giving you a 5p bonus for bringing your bag? Because, charging

5p saves more bags than paying a premium of 5p for bringing bags to the supermarket. Since the introduction of 5p bags in the UK, six billion fewer single-use plastic bags will be taken home this year.

A study of employee compensation showed impressive results. Employees doing the same job were split into three groups.

The first group was offered a bonus at the end of the year for hitting their targets.

The second group was offered no bonus.

The third group was offered a bonus at the start of the year with the condition that they'd have to pay back the bonus if they didn't hit their targets.

Guess which group did best? The third group performed significantly better than the other groups.

Teachers can apply this learning to students and grades. Teachers that gave everyone As at the start of the year and told students they had to maintain good test scores to keep those As performed better than students who had to earn grades in the more traditional way - by starting at the bottom and reaching up.

Interesting stuff.

People are irrational, which is why healthcare marketers and salespeople focus so much energy on framing, using psychological pricing, and reducing the fear of loss wherever possible. Join me in my 1 hour seminar on how to motivate your patients, and you too can learn how to think irrationally. ■

ESCRS Practice Management and Development Programme: Building a 20/20 practice

Monday, 12.9.2016 8.30 - 17.00

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More accurate and objective evaluation

Innovative tools and imaging in **ocular surface diseases**

REIMS - Ocular surface diseases (OSDs), especially dry eye, are recognised as a growing public health problem and one of the most frequent reasons for seeking eye care. Dry eye is estimated to affect over 30% of the population depending on the diagnostic criteria. It is likely to be overlooked because it tends not to be a common cause of visual morbidity as standardly measured.

In clinical practice, the main difficulty in managing OSD results from the variability of symptoms, lack of a single diagnostic test, and poor correlations between clinical signs, visual tests, and patient-reported life disturbance. The definition of

dry eye has evolved with recent epidemiological studies as well as a better understanding of the pathophysiology of the disease. In 2007, the International Dry Eye WorkShop gave a precise definition that originally included the concepts of visual disturbance, inflammation, and tear film hyperosmolarity. More recently, the ODISSEY European group raised new criteria for the diagnosis of the disease, among others contrast sensitivity, aberrometry, and specific inflammatory markers. Today, research efforts are geared towards identifying new markers to better detect and evaluate the severity of ocular surface disease, which is still a crucial issue for the clinical daily

practice as well as for multicentre trials and future treatment evaluation.

Over the last few years, several new tools have been developed or applied to OSD. On the one side, specific devices have been used to quantify or facilitate the detection of ionic, protein or cell pathological changes at the ocular surface, among others conjunctival imprints combined with flow cytometry to quantify cell marker expression such as HLA-DR, cytokines and chemokine receptors, dedicated test to evaluate MMP9 expression, tear film osmolarity or proteomic assays/chips for tear film analysis, etc. On the other side, another branch of research consisted in improving the

evaluation of the visual impact of OSD, and related degradation in quality of life, including tear film imaging, dynamic corneal topography and aberrometry, and dedicated visual/daily task testing. For instance, dynamic aberrometry recently contributed to define new index to diagnose and evaluate the severity of dry eye disease, opening the perspective of accurate surrogate markers for OSD. Other dedicated devices including reading performance evaluation and specific driving simulators contribute to better evaluation of the daily impact of the disease.

Together these innovative methods bring new information that improve

our understanding of the pathophysiological processes and allow a more accurate and objective evaluation of the disease, offering new insights into the therapeutic management.

Main Symposium: Management of the Ocular Surface before and after Refractive Surgery

Tuesday, 13.9.2016 11.00 - 13.00
Auditorium A

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