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References

1. Hosie A, Davidson PM, Agar M, Sanderson CR, Phillips J. Delirium prevalence, incidence, and implications for screening in specialist palliative care inpatient settings: a systematic review. Palliat Med 2013;27:486–498.

2. Leonard MM, Nekolaichuk C, Meagher DJ, et al. Practical assessment of delirium in palliative care. J Pain Symptom Manage 2014;48:176–190.

3. Gaudreau JD, Gagnon P, Harel F, Tremblay A, Roy MA. Fast, systematic, and continuous delirium assessment in hospitalized patients: the Nursing Delirium Screening Scale. J Pain Symptom Manage 2005;29:368–375.

4. Breitbart W, Rosenfeld B, Roth A, Smith MJ, Cohen K, Passik S. The Memorial delirium assessment scale. J Pain Symptom Manage 1997;13:128–137.

5. Victoria Hospice. Palliative Performance Scale (PPSv2) version 2 2001. Available from https://www.victoriahospice.org/sites/default/files/ppsv2_english_-_sample_-_dec_17.pdf. Accessed July 29, 2019.

6. Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the Confusion Assessment Method: a new method for detection of delirium. Ann Intern Med 1990;113:941–948.

7. Jones RN, Cizginer S, Pavlech L, et al. Assessment of instruments for measurement of delirium severity: a systematic review. JAMA Intern Med 2018;179:231–239.

8. Inouye SK, Kosar CM, Tommet D, et al. The CAM-S: development and validation of a new scoring system for delirium severity in 2 cohorts. Ann Intern Med 2014;160:526.

9. Schuurmans MJ, Shortridge-Baggett LM, Duursma SA. The delirium observation screening scale: a screening instrument for delirium. Res Theor Nurs Pract 2003;17:31–50.

10. De Jonghe JFM, Kalisvaart KJ, Timmers JF, Kat MG, Jackson JC. Delirium-O-Meter: a nurses' rating scale for monitoring delirium severity in geriatric patients. Int J Geriatr Psychiatry 2005;20:1158–1166.

Behavioral Economics: Applying Defaults, Social Norms, and Nudges to Supercharge Advance Care Planning Interventions

To the Editor,

Care that people receive at the end of their lives is not always consistent with their goals and values.[1] Incongruent care can have emotional and financial

consequences for individuals, families, and the overarching health care system.[2] Advance care planning (ACP) is a lifelong process that elucidates a person's goals and values in the event of serious illness. However, despite policy changes, system overhauls, and educational interventions, only one-third of people in the U.S. have completed some form of an advance care plan.[3] To realize the potential benefits of ACP, alternative approaches to designing ACP interventions are needed.

Considering the behavioral nature of ACP, Behavioral Economics (BE) offers an innovative approach to ACP intervention design. BE explains people's choices in real-world contexts where they use decision-making shortcuts and make predictable errors.[4] These key insights can be used to reengineer behavior change strategies and supercharge existing ACP interventions making them more effective in the complex health care environment. This Letter identifies three key BE concepts, defaults, social norms, and nudges, and their potential applications in the design of ACP interventions.

Discussing BE in the context of ACP intervention design may raise ethical concerns, harkening back to an era of paternalism. Some may worry that interventions manipulating how information is presented to influence behavior are exerting too much control over individual choice. First, it should be clarified that BE strategies may alter the way information is presented, but importantly, never restrict choice. Incorporating debriefing alongside ACP interventions can give individuals the opportunity to reevaluate their choices, preserving autonomy. Importantly, this honors a key principle of ACP, to continually revisit choices and ensure they are consistent with wishes that may evolve over time and context. In addition, how information is presented always reflects a bias, even without experimental manipulation, and therefore already influences people's decisions. Examining ACP with a BE lens encourages investigators to understand how people make decisions and explicitly acknowledge, as well as explore, that the way we structure choice can influence this process.

Default Bias: Making Preference-Consistent Choice Easy

When given a choice, people tend to stick with the default, or rather, avoid the cognitively taxing chore of making an active choice to the contrary. Defaults can be leveraged to make choices that are aligned with a person's stated preferences easier to make. For example, changing the default in a retirement savings plan from no contribution to a standardized percentage increased retirement savings by more than fourfold, setting more people up for future financial success.[5] This popular new default has been adopted by many employee sponsored retirement savings plans to ease the burden of making a decision now for our future selves.

The default in the U.S. health care system is life-extending care. However, most people in the U.S. endorse a preference for comfort over longevity at the end of their lives,[6] requiring the majority of individuals to make the challenging shift away from the default. Experimentally changing the default from life-extending care to comfort-oriented care on ACP documents led people to choose comfort-oriented care to a greater degree.[7] Furthermore, this choice remained constant even after being made aware that the default was changed.[7] This research demonstrates that defaults in ACP are powerful and investigators should evaluate the risks and benefits of how they structure choice. Understanding this effect in more vulnerable populations, such as people with cognitive impairment or low health literacy, is warranted.

In addition, theorized provider and patient-directed defaults can be used to promote timely ACP. For example, EHRs could prompt providers to have and document ACP discussions with specific patient populations and require an active opt-out. ACP resources could be included in welcome packets for Medicare enrollees and/or new assisted living residents. Accordingly, future ACP interventions should consider how information is presented might influence choice.

Social Norms: Making ACP Social

People engage in social comparison and are strongly influenced by others' behaviors. Because discomfort with death represents a social norm in our society and talking about dying is taboo, behaviors like ACP are largely invisible.

One way to leverage social norms is to make ACP more social and more visible. In one classic study, hotel guests were more likely to reuse their towels when signs were posted promoting descriptive norms (e.g., "most hotel guests reuse their towels").[8] Relative to ACP, spearheaded by the Hospice and Palliative Nurses Association, the social media campaign #IsaidwhatIwant promotes nurses to lead by example, to establish their own advance care plan and then share their story. This campaign leverages social norms to increase engagement with ACP. Future ACP interventions publicizing that many individuals do in fact have and document ACP conversations with their providers could enlist the bandwagon effect in a positive way to encourage more individuals to participate in these behaviors.

Similarly, providing social norm feedback to health care providers can help individuals who are outliers adjust behavior toward the social norm. Interventions using this tactic have reduced unnecessary prescription of antibiotics by general practitioners.[9] Making the ACP conversations of providers more visible to

other providers could be effective to influence individual clinician behavior and should be built into future ACP study design.

Nudges: Bringing ACP to Life by Making Benefits Immediate

People put off planning for the future in favor of pursuing gratification in the present. This present bias makes engaging in ACP challenging as the immediate costs of engaging in a potentially uncomfortable conversation in the present may outweigh future benefits that are intangible and difficult to appreciate.

Providing strategically designed financial incentives make future benefits more tangible helping to overcome present bias. Incentives have been used to successfully modify other health behaviors, like smoking cessation, and early results show promise that incentives can modify ACP. A study examining the efficacy of financial incentives for ACP found combined provider-patient financial incentives compared to provider incentives alone increased ACP discussions.[10] Future research examining the magnitude and timing of incentives to promote ACP is necessary to explore the optimal structure of this strategy to overcome present bias.

Beyond financial incentives, there are other strategies to make the benefits of ACP more readily appreciated. Individuals who have recently experienced a change in their health status leading to hospitalization or a transition in living, or those who have just navigated health care decision-making on a loved one's behalf, may be primed to realize the benefits of ACP. Designing ACP interventions to target these individuals helps harness the reality that events that are close at hand are more salient than those far in the future.

Conclusion

Insights from BE can inform ACP intervention design to use strategies based on the way humans actually make decisions in the real world. This Letter presents lessons from early trials in palliative care leveraging the default bias and nudges to overcome present bias, and findings from other health contexts making invisible behaviors more social, which can enhance future ACP interventions with behaviorally informed elements. Palliative care providers and scholars are well positioned to design, implement, and test these behaviorally informed strategies given their strong ethical foundation in person-centered care. More research is needed to evaluate the effectiveness of these techniques within the realm of palliative care, and BE strategies do not negate the need for overarching systemic change. However, BE holds promise as one approach in a set of tools to boost current intervention design and promote ACP grounded in the realities of decision-making in a complex world.

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References

1. Institute of Medicine Committee on Approaching Death. Addressing key end-of-life issues. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington D.C.: National Academies Press, 2015.

2. Brinkman-Stoppelenburg A, Rietjens JA, van der Heide A. The effects of advance care planning on end-of-life care: a systematic review. Palliat Med 2014;28:1000–1025.

3. Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. Health Aff 2017;36:1244–1251.

4. Hanoch Y, Barnes A, Rice T, eds. Behavioral economics and healthy behaviors: Key concepts and current research, 1st ed. New York: Routledge, 2017.

5. Thaler R, Benartzi S. Save More Tomorrow™: using behavioral economics to increase employee saving. J Polit Econ 2004;112:S164–S187.

6. Fried TR, Bradley EH, Towle VR, Allore H. Understanding the treatment preferences of seriously ill patients. N Engl J Med 2002;346:1061–1066.

7. Halpern SD, Loewenstein G, Volpp KG, et al. Default options in advance directives influence how patients set goals for end-of-life care. Health Aff 2013;32:408–417.

8. Goldstein NJ, Cialdini RB, Griskevicius V. A room with a viewpoint: using social norms to motivate environmental conservation in hotels. J Consum Res 2008;35:472–482.

9. Hallsworth M, Chadborn T, Salli A, et al. Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomised controlled trial. Lancet 2016;387:1743–1752.

10. Barnato AE, Moore R, Moore CG, Kohatsu ND, Sudore RL. Financial incentives to increase advance care planning among Medicaid beneficiaries: lessons learned from two pragmatic randomized trials. J Pain Symptom Manage 2017;54:85–95.