

How small changes to choice design can help pharma brands drive better prescribing outcomes

MichaelAaron Flicker: [00:00:00] Welcome back to Behavioral Science for Brands, a podcast where we bridge the gap between academics and practical marketing. Every week, we sit down and go deep behind the science that powers great marketing today. I'm MichaelAaron Flicker.

Richard Shotton: And I'm Richard Shotton.

MichaelAaron Flicker: And today's episode, we're looking at how healthcare brands can apply behavioral science and what all of us can learn from it.

Let's get into it. So Richard, you know this from our years of working together, but my introduction to behavioral science came almost 14 years ago when working on healthcare brands. And so the fact that we're taking an entire episode today to go deep, I'm just very excited about it. I think it's gonna be something that if you're in the pharma space, if you're a healthcare brand, obviously, we hope you'll get a lot out of it.

But you and I feel everybody who listens to this can get a lot [00:01:00] out of it, whether you're in the pharma space or not.

Richard Shotton: Yeah. It's a category. I think there are huge potential applications. It's such a big category. There's such huge spends on advertising and marketing that some of the costless principles you can apply from behavioral science should be very effective

MichaelAaron Flicker: Yeah.

And when I started in this category, I was working for a multinational pharmaceutical brand, and there was a stat that I knew 14 years ago, and I went and looked it up in prep for today's episode, and it's astonishingly unchanged. So back in 2003, the World Health Organization came out with a report that said roughly 50% of patients with chronic illnesses don't take their medications as prescribed.

And despite all of the advances in medicine, digital health [00:02:00] tools, apps, wearable technologies, the most recent data we have suggests that number hasn't really changed. And if you think about it, that's remarkable because these are often treatments designed to save people's lives, improve their health, and yet they're not really getting any more uptake today than they had in the past.

So I think it's a reminder to me as we get into today's episode, healthcare marketing, pharma marketing isn't just a medical challenge, it's a behavioral challenge. How do we help people think and feel differently so we can actually motivate different behaviors, not just how can we overload them with information, which clearly as nobody listening here will be surprised, is not gonna be our recommendation.

So how can we help people get to a better life? It materially affects quality of life, and it literally can be life or death in some [00:03:00] instances.

Richard Shotton: Yeah. And if you think of it from the perspective of those pharmaceutical brands, this is a crazy situation to be in. I mean- they are spending tens maybe even hundreds of billions of dollars on developing these amazing drugs, yet there's far less emphasis on how do we position those drugs in the most effective way to encourage adherence.

So maybe there's an argument of a, a rebalancing slightly. Put a tiny amount of the money that goes into the creation of the drug into ensuring that 50% figure becomes much, much larger.

MichaelAaron Flicker: It's an interesting point. And for all of our listeners whether we can, w- we can learn from what these healthcare brands have stacked against them because it gives us a real insight.

Even if the carrot is healing your heart from a heart attack, [00:04:00] even if your carrot is reducing a chronic disease that's sometimes still not enough to get you to take your medicine every day. So we wanna think about just how good the carrot is and just how good the the interventions are to get, help get us there.

And it's a great opening for us. And Richard, as we get into the episode, a big thanks to listener Judy Bernstein, who suggested this as a topic for us, and we thought, wow, like what a fantastic idea. We both have history in it. How can we use it as a jumping off spot? So we structured today's episode in two parts.

First, how can healthcare brands better communicate with patients? And then we're gonna go second to the opposite side of the house. How can behavioral science help influence doctors and healthcare professionals more effectively? So we're gonna look at these, and we're gonna find a foundational behavioral [00:05:00] science principle, and then we're gonna introduce something a little bit more fun, a little bit more exciting for everybody listening So shall we get into our first bias?

And this is one we've hit before. We call it the ostrich effect. And you and I love the name, but what it teaches us about human nature is really important.

Richard Shotton: Yes. So the ostrich effect is essentially the idea that if you communicate in a way that scares the audience or makes them feel ashamed, they will often, the audience that is, they will often ignore the messaging.

The reason it's called the ostrich effect is they metaphorically stick their head in the sand. We have discussed this before, but we've often talked about it in the world of finance. So there's some amazing studies by George Loewenstein at Carnegie Mellon that show if people think their ba- bank statement is gonna give them bad news, they're much- Yikes

less likely to look at it than if they- Yeah ... think it'll give them good news.[00:06:00]

But this bias also affects people in a medical setting. So there's a 2013 study by Josh Tasoff, who's at Claremont Graduate University, and he recruited a group of people, and they all have blood taken. So they go through the hassle and the slight pain of taking or giving some blood, and that blood is used to do a genital herpes test.

Once that's been done, people are given an offer. They can either find out the results of the test and be given \$11, or they can not be told the results and they get \$1. Now, e-exactly. In, in many respects, this is from a logical perspective, an insane choice. Surely everyone would go for more cash and the benefit of extra [00:07:00] information.

Get the information. If you wanna ignore it, you, you can do, but you've at least got the information and you've got the money. But even though it is such a stark choice, 15% of people decide not to get the results. They would rather have less money, \$10 less, and live in ignorance because the idea of having some bad news puts them off.

That is the ostrich effect. And I think when it comes to communications from healthcare brands, there are lots of implications. The main one being it might feel logical and sensible to tell people about the horrors of what might happen if people don't take their medicines or don't adopt certain healthy behaviors.

But what this study suggests is that approach can often backfire

MichaelAaron Flicker: And in the study itself, the most cited reason for opting out was, quote, "unnecessary stress or anxiety." You and I [00:08:00] sometimes talk about how folks are strangers to themselves. They may not know why they do certain things. In this instance, those that turned down the \$10 and the knowledge of that genital herpes test seem to know quite well that they do not want the information that's behind that door.

Richard Shotton: Yes. People would rather have the comforting ignorance that- Yes ... has peace of mind rather than knowledge which might bring with it fear and bad news. So i- it is a real challenge because if you have the mental model of humans being rational decision-makers, just simply and dispassionately weighing up information in front of them, the sensible thing to do as a healthcare brand is to make the downside of not adopting a behavior or not getting a test feel absolutely [00:09:00] catastrophic.

But when we look at experimental data and seeing, see how people actually respond, this kind of study from Tasov and other ones by Lowenstein suggest those scaremongering approaches will often backfire.

MichaelAaron Flicker: And it strikes me, you mentioned before we got into this study, we've talked about this in financial planning, but whether it's financial planning, insurance, cybersecurity, I see a lot of this on TV, or medic-medicines When people feel threatened, I think it is effective at grabbing attention.

It does cut through the clutter. "Don't miss this. Your rebate won't come. Don't miss this your health is on the line." I think it may be useful at grabbing attention, but it feels terrible at getting the action that you want. So it may be good in one se- in one sense of breaking through clutter, but it may [00:10:00] not be good at sustaining that action or getting the outcomes that you want if it is fear that you're using to g- to gr- get that action.

Richard Shotton: Yeah, and certainly with this Tasoff study, it's the action that is the metric they monitor, and that's what performs badly. And most brands are

mainly interested in action. The awareness and attention is often a kind of necessary precursor of action, but it's really just a proxy message.

What we really want is people to do things differently. So brands should be optimizing to what creates action rather than what just creates attention.

MichaelAaron Flicker: To me, that feels like a big opportunity because it's up to the brand in the communication to deliver this moment of, if you want to say fear or you want to say this moment of seriousness, but that next action that it sets up may be really the key of what should happen next.

So if you make the next action schedule a two-hour [00:11:00] doctor's appointment to learn more you can imagine nobody's gonna do it. If the next action is g- go to this website that seems a lot easier. If the next action is talk to a friend or family member you've lowering the next action more and more to maybe make that next step more achievable or more attainable.

To me, it really, it's the job of us as marketers to make that next action actually achievable to keep the momentum from grabbing their attention in the first place.

Richard Shotton: I think there's certainly an argument that fear messaging is most likely to backfire if change is hard. Now, some of the hardness of a behavior is within our control.

As you say, don't ask people to go to a two-hour meeting. Maybe it's a two-minute action instead. But I think when it comes to finding out you've got genital herpes, the difficulty is the, is maybe [00:12:00] the stigma that comes with it. Maybe the fact you've gotta abstain sexually for two months.

Then-- so it's something like this, it's e- it's very hard to make-- t- to address it because it's not just the, the kind of physical and cognitive load of organizational, it's the social stigma and the ef- effects on what you can do that is the hardest.

MichaelAaron Flicker: And maybe what it says about yourself.

If finding this information is in contrast with the identity, self-view that you have of yourself. W- we're talking about pharma and maybe a sexually transmitted disease, but if you think that you're a great financial planner and finding out this next information is going to show you that you've actually lost a

lot of money it's that break with the consistency of how you see yourself that may give you a sense of how hard it is for someone to do something.

So if it is, if it's [00:13:00] in contrast to what their normal view of themselves is, that may be helpful for us as brand marketers and product marketers to evaluate in my business case, how applicable is this insight? It may be that if there is a strong break with their normal state, that's really the indicator for brand marketers that m- this, this effect may be happening.

There-- Or this, this bias may be in effect here.

Richard Shotton: Yeah. And we talked about a lot of the challenges that this poses for health communications, but there are workarounds. We've talked in our previous podcasts about anti-smoking messaging- how that has adopted a much more positive tone o- over the last few years in a l- awful lot of governmental messaging.

So I think there's a an interesting case study there. And also, specifically in the area of herpes when Jo Arden came on, she talked about the New [00:14:00] Zealand campaign that tried to-

MichaelAaron Flicker: Yes. Yes ...

Richard Shotton: make getting a test feel a very small thing, that lots of other people were doing it that it was something that was a very matter of course.

So I think there are alternatives to this scaremongering.

MichaelAaron Flicker: Joe Arden, episode 95, for those that wanna take a jump back in time. But yeah, I think you're right. She, like the anti-smoking work we w- have been talking about in some of the previous episodes, she showed how the herpes, if they made it light and they made it destigmatized, it gave it a, it gave it a much l- more likely a chance for folks to deal with it.

And again, to me it, in destigmatizing it, it helped them more face it rather than feeling like they had to stick their head in the sand. They had to ignore it completely. So it's about changing the conditions for how they feel about the stigma, in that instance seemed to be [00:15:00] effective there.

Richard Shotton: Yeah.

Yeah.

MichaelAaron Flicker: So we have a second, and as we promised, a little bit more surprising bias for patients.

Richard Shotton: Yeah. So th- this one, I think it is surprising. There, there's two reasons I thought this would be a super useful study to go through. Firstly, the impact is surprising 'cause it's quite a small change.

It's it's something everyone can do, but it has a large impact. And then secondly, the ostrich effect maybe only applies to some communications. There's lots of challenges to getting it right. This is super easy to apply. So it's known as the picture superior-superiority effect, and it's the idea that we notice and remember images much better than text So the study, which to my shame I have misattributed previously, I seem to have this mental block.

The actual study is by Daniel Morrow [00:16:00] University of New Hampshire, 1998. I think on previous episodes I may have referred to him as Daniel Marrow or Daniel Yarrow, but it is definitely Daniel Morrow, University of N- New Hampshire. So he does this experiment, and it's, gives people information about when to take some pills across a day.

Some people get a text explanation, just written down when they should take it, and it's not a hard set of instructions. That's the kind of key thing, and 81% of people remember to take their pills at the right time when they're questioned later. Second group of people, they get the same text instructions, but this time there is a very simple graphic that accompanies the text.

So a simple graphic, you know, dotting out when people should take those, those pills. And in that setting, when Morrow goes back and questions everyone [00:17:00] about when they should take their medication, 90% of people put the cor- correct response down. Now, at first, that doesn't sound like a very big change, and I've set it up as being this massive change.

You've gone from 81% correct to 90%, so there's an 11% uplift. But if you think of it the other way around, in the first setting, 19% of people made a mistake on, in their recollections. In the second setting, when there was the image as well, that number has dropped to 10%. So mistakes- Yeah. Yeah ... Have halved.

So it is a very significant way of avoiding error. And secondly, it is ridiculously simple. This isn't about clever copywriting, amazing strategic insight spending huge amounts of money. It is the very simple idea that image plus text [00:18:00] tends to be more effective in creating memory and recollections and notability than text alone.

So it's something that lots and lots of brands can apply.

MichaelAaron Flicker: It reminds me of this quote "Communication is in the receiver." And it's so easy to forget that patients are getting this information from the doctor, prescribing information when they're under stress or they're overwhelmed or they get it as a big block of text alone in this instance, right?

They're receiving it all as, as text, and a simple graphic can help really ease that information processing and make it much easier to understand, "Oh, this is how I can commit it to my memory structure. This is how I'm going to act on it."

Richard Shotton: Yeah. And that's a great point about the situation that the, the patient's in.

The problem for doctors is if they are, I don't know, [00:19:00] a bladder specialist or an oncologist, they're dealing with bladder problems and cancer every single day, and it's not affecting them. Now, it doesn't mean that they're not affected at all, but they're certainly not affected in the same way as the recipient of bad news.

And also, they are experts in this area. They have spent 20, 30, 40 years, whatever it is, learning about the intricacies of bladders and cancers. So it's very easy as an expert to forget what it's like not to know all this information. In fact, I think we had an... Oh, yeah, go on. Yeah.

MichaelAaron Flicker: No, please.

Richard Shotton: I was just gonna say, we had a previous podcast Gareth Harvey, and he was talking about experiments he'd run, I think it was with vets, and he said, when a vet gives a bit of bad news, what they should do is they're not trying to convey any more information for a minute or so. I [00:20:00] don't mean they should sit in silence, but it shouldn't be more information.

It should probably be focusing on empathy, because he said there is this emotional blink. I think that was the term he used. So you hear bad news, and then that's all you focus on. All this other information coming in is com-washing over you. So I think there's an awful lot that doctors could do if they can put themselves in the shoes of their patients more regularly.

MichaelAaron Flicker: I think it's a lovely point. So we have this first idea that an image with text is gonna be more memorable than text alone. We have this second idea that we're building on that understanding the receiver and the

moment that the receiver's getting this information is more critical than just getting the information out there.

And maybe the third point that pushes the idea a little further is we shouldn't confuse this with just a picture by itself is better. It's i- and a [00:21:00] picture that's overly complex or overly diagrammed probably does more harm than good. So it's a simple picture that clarifies, that makes it easy to understand.

It's really about cognitive offloading. It's about reducing the mental load. That's what the picture does- Yeah ... effectively in this study.

Richard Shotton: That is a very good point and one I think worth doubling down on. This isn't a picture of a smiling clinician in a- Yeah ... in a white coat. It was a diagrammatic picture essentially showing visually when the pills should be- Yeah

should be taken. So take

MichaelAaron Flicker: one at sun up and one at sun down, or something like that. E- I think

Richard Shotton: it was that idea. Exactly. And we'll put those in the, the show notes so people can see it and it'll all be a bit clearer then.

MichaelAaron Flicker: But the point is we're gonna use-- we're gonna be thoughtful about how the receiver gets information, and if a diagram helps reduce it, like in this study, man, we half the amount of mistakes.

And I think [00:22:00] your- Yeah ... your reframing of that is so effective because we're saying- Yeah ... "Look how mu- look how many mistakes we took off the table because of this."

Richard Shotton: And for pharma marketers and doctors not to fall into the trap that because something is blindingly obvious to them, don't believe that it will be blindingly obvious to the patient.

I think that's a, a key bit as well.

MichaelAaron Flicker: And when we're seeking other types of behavior change in commercial marketing, there's a real takeaway here. How can we even take something that seems very understandable and put ourselves in the shoes the first time you buy a wardrobe from a new company?

You don't know how it's gonna fit. So the the simple sizing charts that show you these types of body shapes are best with these sizes. Any way you can visually diagram and ease that tension before a purchase can likely make it a, a much better experience for the buyer. So we could [00:23:00] take this same idea that we have in the medical industry and say, " we can apply this outside in other marketing fields if we just think about the receiver and how to reduce that cognitive load."

So we've now wrapped up part one, how to communicate with patients, and we wanna move to part two, how to communicate with doctors. And n-now we're challenging some conventions here. Am I right, Mr. Shotton? We're trying-- we're not taking any shots at our doctor colleagues, but we are saying they may be susceptible to the same human biases as the rest of us.

Richard Shotton: Yeah that's a very good way to open it. There's often a misperception, there's a bit of a myth that these behavioral science principles are relevant for consumers, but many people believe they won't be relevant for professionals. That surely professionals who are paid to make dispassionate decisions, surely they will just weigh things up [00:24:00] logically and come to the right decision.

But the evidence is very clear that isn't the case. That professionals are as influenced by these biases often as consumers. So one example of that, we've talked again and again when it comes to consumers and patients, that they are influenced by friction. So there's the argument from Daniel Kahneman and Richard Thaler that if you want to change behavior, one of the best things you can do is focus on making it easy rather than just trying to motivate people to want to change.

And a lot of the evidence that supports that, and a lot of the examples we've talked about in the past relate to small commercial decisions. But there is an amazing twenty eighteen study by David Olshan, who's at the Penn Medicine unit, where he shows that doctors and their prescribing behavior can be deeply influenced by very small bits of friction, very small [00:25:00] barriers.

So over three years, Olshan looks at prescribing behavior, so from Jan twenty fourteen to May twenty seventeen. And for the first part of that period, he is looking at doctors where if they want to prescribe medicines, they have this drop-down menu. So they put in their symptoms, and then they work out what the issue is, and then there's a list of drugs that they could prescribe Now, for the first part of the data collection, when doctors looked at that dropdown menu, the branded drugs were at the top, generic drugs at the bottom.

So for people not familiar with that terminology, when a pharmaceutical company invents a drug, it's patented, it will go under a brand name, and it will be quite expensive. After a certain amount of time, other companies are allowed to replicate that drug. They can make the kind of [00:26:00] same pharmacological pill, but they will sell it under a generic name.

So you've got the branded drug, the original expensive one. You've got the generic drug, pharmacologically the, the same, but much, much cheaper. So there's a big incentive for hospitals to want doctors to prescribe the generic.

MichaelAaron Flicker: So

Richard Shotton: first part of the situation, doctors are going to their computers, drop-down menu, brand is at the top, generic's at the bottom.

And what Olshan finds is that in this setup, 75% of the drugs prescribed are generics. But then in 2017, Olshan intervenes. He changes the setup of the prescribing interface, and now y- he flips the order of the drugs. So when doctors go in, there are generics at the top and then branded drugs at the bottom.

So if a doctor wants to prescribe a branded drug, they can still do it, but it takes them two or three [00:27:00] seconds more effort. Now, that tiny extra bit of effort has a big change on prescribing behaviors. You've now got 98% of the drugs being prescribed- Wow ... that are generics. So that is a 31% uplift. So the, the key point here is even this group of very well-educated professionals who define themselves as being logical, rational decision-makers, even they are very influenced by small bits of friction.

So if you want to change the behavior of a doctor, don't just give them lots of information about why they should change. Think to yourself, "Is the thing I want to do very easy for them? Is the thing they shouldn't be doing reasonably hard?"

MichaelAaron Flicker: To me, one of the lovely things about this study is we are often so focused in our podcast on communications and changing beliefs, but in this instance, there [00:28:00] was no persuasion required.

There was no communication to be had. We changed the operating environment, and the behavior changes. And so to me, it's a really important lesson that we can change the behaviors of certain actors by changing the game itself, by changing the processes that we ask them to follow. And to me, that can have enormous behavioral outcomes.

We we can think about not just how much friction we wanna add-- w- take away, which we spend so much time talking about. We can also say, how much friction do we wanna add to get to an outcome that we want? And sometimes the biggest outcome could come from just changing the default rather than changing the communication a-altogether.

Richard Shotton: Yeah, I think the argument from [00:29:00] Kahneman and Thaler would be, before you think about how best to motivate an audience to change, the first thing you should do is think h-how can I make the desired behavior as easy as possible? And- Often removing friction has an outsized effect, a surprisingly large effect on behavior, and that's probably the place where people should start.

But I think in most cases, marketers don't do that. Marketers are obsessed with motivation and appeal. And it's not that's completely irrelevant, that'd be insane to say that, but we often overestimate the impact of appeal, underestimate the importance of ease.

MichaelAaron Flicker: I think that's brilliantly said. And focusing only on friction I think it maybe is oversimplified to say we should just make everything frictionless.

We what you said is the to me, the more sophisticated way to say it Friction itself is neutral. The real question is what's the behavior [00:30:00] that we're trying to encourage or discourage? We wanna make prescribing op- opioids harder. We wanna make reaching suicide prevention hotlines easier.

Like friction can be used in both ways for the outcome that we want. Yeah. So as you say, it's about how do we design the right system to get to the outcome that we want. Y-

Richard Shotton: yes. We often say make it easy is our kind of catchall term for this, this area. But you're absolutely right, it's a bit more than that.

It's make it easy if you want this thing to happen, make it hard if you don't. And you specifically mentioned suicide. There is some fantastic analysis done by Keith Horton at Oxford University into suicide rates in Britain from paracetamol overdoses.

And he looked at annual suicides, and what he found was that when the government made it harder to commit suicide by paracetamol, you saw this long-term decline [00:31:00] in deaths by that means.

And I think post the legislation changes, about 400 deaths have not occurred because of this added bit of friction. So what the government did, up till maybe around 2000, I'm not quite sure of the right exact date, in Britain you could go to a corner shop and buy a tub of 64 paracetamol. Now the legislation is the maximum number of paracetamol you can buy in a corner shop is I think 16, and I think it has to always be in a, a blister pack.

So if someone wanted to commit suicide by that means, they would have to go round four different corner shops to get the necessary pills. It might seem that would be a trivial barrier considering the importance of the decision. What's a bigger decision than- Yeah ... whether you're gonna take your life?

But even in this huge important decision, small bits of friction have a large effect [00:32:00] because what you're doing is slowing people's decision-making process down by maybe half an hour. That gives them enough time, on occasion, to reflect and change their mind. So any situation you look at, thinking about adding or removing friction is one of the most crucial things you can do.

MichaelAaron Flicker: Paracetamol, for those listening in America- also known as acetaminophen or the brand name Tylenol in America. But same, same drug. And interestingly, in America, we have a very similar restriction on Sudafed, which is like pseudoephedrine, which which has been used to make drugs.

So similar thing. They add a limitation on how much you can buy in any one store in any one state, and they-- And it's really created a real downward, positive downward usage of those drugs, Yeah ... in [00:33:00] in creating illicit drugs. So it's a good outcome there. Yeah. And now we have a second, and as we like to say, maybe a little bit more surprising- Yeah

bias about doctors. If this one you could have guessed, this one maybe you would be less likely to guess.

Richard Shotton: Yes. And the only thing I would say on that is I think there is always a danger talking about friction, that some listeners will roll their eyes and think, " this is bleeding obvious.

Everyone knows if you make-" something harder, it happens less. You make it easier, it happens more." The, the key thing though is not just changing friction levels, it's the fact that it has a surprisingly large outcome. So I think most

people know adding friction will slow things down. What they don't get right is quite the scale of the impact.

And because they don't estimate the impact to be as large as it actually will be, they don't do that behavioral tactic as regularly as they should.

MichaelAaron Flicker: And just to restate that one [00:34:00] more time from the Olshan study that you quoted, Richard, all they looked at was if they put the generic prescription drugs at the top of the list versus at the bottom.

Just moving it to the top gave a 31% uplift in the effectiveness of choosing that over the branded drug. So really a big outcome for a very minor change, the order of the drugs listed in the dropdown menu. Shall we move to our- Yes.

Richard Shotton: Yes ...

MichaelAaron Flicker: final surprising- Yeah ... bias for today?

Richard Shotton: So this one is called decision fatigue, and it's essentially the argument that if people have to make cognitively, cognitively demanding decisions throughout the day, they'll be happy to do them in the morning.

But over time, they will become increasingly averse to that effort, and they will start to plump for the simpler [00:35:00] alternatives more and more as the day goes on. So there is a study into this from 2014. It was by Jeffrey Linder at Harvard Medical School, and he was looking at when antibiotics are inappropriately prescribed.

MichaelAaron Flicker: Okay.

Richard Shotton: So this is a big concern for many countries or for the population of the world, in fact, because the more antibiotics are inappropriately prescribed, the greater chance there is of microbial resistance. So there's big problems from overprescription. Now, Linda looked at 21,867 patient visits to doctors across 23 practices, and people were coming in for acute respiratory infections.

So this is a, a problem which generally doesn't need antibiotics. So [00:36:00] he then looked at the data of when antibiotics were prescribed by hour of day, and what he found for both general prescriptions and inappropriate prescriptions of antibiotics, you see the same pattern. So beginning of the day, it's starting off

with quite low prescription levels maybe about a quarter of visits get antibiotics, and then that prescription rate rises till you get to lunch.

Doctors come back from lunch off a bit of a break, and it has dropped down a little bit, and then it rises again in terms of prescription rates till you get to the end of the day, four o'clock, five o'clock, when that's when prescription rates peak. Now, Linda's argument is this is an example of decision fatigue.

The right thing to do, the correct thing to do is not prescribe those antibiotics, but it's a bit of an awkward conversation with the patient. What doctors know is if you want to get the [00:37:00] patient out the room, you hand them some antibiotics, they're very happy. They feel like things are progressing. They feel like they're doing something to resolve the problem.

It's the easy decision to give out antibiotics inappropriately, and what Linda shows is that as the day wears on, as people get tired, as they've had lots of draining conversations, that easy but wrong decision is more likely to happen.

MichaelAaron Flicker: As organizations and companies that design policies and procedures, it seems so easy to set one policy for doctors to follow.

But what this shows us is, y- you, there's a, the, people are not gonna perform identically the same at 8:00 AM and at 5:00 PM, and so we need to know that people's natural predilections are gonna change as they take on more of that burden throughout the day. And so there may need to be different [00:38:00] interventions to counteract that.

Richard Shotton: Y- yes. Yeah, ab- absolutely. I always think there's an awful lot to be said for working with human nature rather than against it. It's a much more effective thing to do. So let's say you are a pharma company, and you've created this amazing new drug, better in all sorts of different ways from the existing standard thing that's prescribed.

What often happens is doctors are creatures of habit like everyone else. People, pharma companies often find their great new medicine isn't prescribed as much as they would expect from its performance. So if you want to go in Have a conversation with the doctor and try and get them to change their prescription habits, which is effortful.

I think the argument from the Linder study would be get in as early as you can. If you get to the end of the day what people are gonna wanna do is take the easy decision and just keep on prescribing the same things they always have. If you

want [00:39:00] your medicine to get a fair chance of proper neutral evaluation, reaching people in the morning, reaching those doctors in the morning would be the ideal approach.

MichaelAaron Flicker: It makes you think about when in the arc of any buying experience, in the arc of any doctor experience, in the arc of any patient experience, there's always gonna be the right moment to insert different behaviors in. And just being more aware of it overall probably will make you more effective.

And then as you say in the Linder study, this tells us where you might be able to introduce a new drug. Strikes me the opposite could be true. At the end of the day, the doctor is just willing to say yes- Well- ... more often. But that's- But you may not get as strong of a yes. Yeah. Yeah. I don't know.

Richard Shotton: Yeah. Yeah. But it-

That's a very good point. So my interpretation of this, 'cause I always find this fascinating. You've got a study. It tells you this point, that people follow the path of least resistance when they are [00:40:00] cognitively exhausted. I had always interpreted that as okay, if you want them to take the hard decision and change their prescribing habits, go early.

But you could argue that people are more persuadable in the afternoon because they can't face that, that kind of argument. Either could work, so maybe there's a test that needs to be done to see which of those plausible explanations is the- Yeah ... is the right one.

MichaelAaron Flicker: And the point is, don't assume that folks are going to perform identically the same all day- Yeah

long. So if you're not getting the response you want, but you keep sending your medical pharma reps to the doctor's office at a certain time every day, maybe change it up. If you're not getting the response rate to your email blast that you want, maybe change the time, right? Th- there is the variables that of when the decider [00:41:00] receives the message vary greatly.

And so testing these different time periods can really have an outsized impact on how effective it you will be.

Richard Shotton: One, one of the best frameworks for behavioral science is EAST, created by the Behavioral Insights team back in 2014. They split

behavioral science down to four big principles Make it easy, which we've discussed.

Make it attractive. Make it social. That is, make it look like other people are behaving the way that you want. And the final T of this framework is make it timely. That is the argument that exactly the same message can have a markedly different effect dependent on when people hear it. So we've often talked with a consumer hat on about reach people if you want to get them to change their behavior just after they've undergone a life event.

Reach them at a fresh start moment. Reach them when their age ends in nine. There are lots of ways of applying this principle of timeliness. Linda's is just one of them.

MichaelAaron Flicker: I love that. Yeah. Yeah As we come to a close, as we [00:42:00] like to do, Richard, can we recap today's episode, hit the highlights of what we've spoken

Richard Shotton: about?

The highlights, yeah. Yeah. So we've talked about an awful lot in this episode. We began by talking about the ostrich effect, so that was the Tasoff study about a genital herpes test. And that is essentially the idea that if you try and scare people into taking their medication or scare them into changing their behavior, if the change that you're asking is quite hard, that fear will often backfire.

People will behave like the metaphorical ostrich. So often it's worth having a slightly more positive element to your communications. The second principle we talked about was the picture superiority effect. Essentially the idea that if you want people to remember information, if you want them to understand information, don't just default to written text-based communications.

Often you can increase comprehension by accompanying text [00:43:00] with a simple visualization or diagram of the information you're trying to convey. And I think we should recognize the guy's name again and again, Daniel Moro, not Daniel Marrow, as I have so often referred to him as. We

MichaelAaron Flicker: apologize if Daniel-

Richard Shotton: We apologize, yes.

MichaelAaron Flicker: Yeah.

Richard Shotton: Yeah. Wholeheartedly. Then we talked about communicating to doctors themselves. We stressed that they are as influenced by these behavioral science insights as their patients. We began with a study into the importance of friction. That was the David Olshan, the 2018 study run at the Ped- Penn Medicine unit, which showed that really small changes to the amount of effort radically changed what doctors prescribed.

So if you want to change the behavior of a doctor, think about first, is the behavior something you want to encourage or discourage? And then think about either removing friction if it's something you want [00:44:00] to encourage, or if you want to discourage, add friction in. Small changes have a disproportionate effect.

And then the final experiment, we got four in, the final experiment we talked about was decision fatigue, that idea from Geoffrey Linder, which was essentially as people go through their day, as they make more and more cognitively demanding decisions, their w- willingness to make hard decisions wanes over time, and increasingly people will take the easy way out.

And then we debated how you could harness that idea to get the right prescription and the right medical behavior happening.

MichaelAaron Flicker: And with that, we say thank you for listening to today's episode. If you found it engaging, please share it with others and and comment on our feeds. It helps us reach more people just like you.

And until next time, I'm MichaelAaron Flicker.

Richard Shotton: And I'm Richard Shotton. [00:45:00]

MichaelAaron Flicker: Thanks for listening.

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