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Proem

The COVID pandemic highlights the impact of our choices about health and habits on ourselves and each other as well as the impact of others' choices on us. Think crowding, masking, vaccinations, collaborative problem-solving. Our lives depend on the choices we and others make. Sometimes our choices have little impact; rather, policy, employers, community culture, work and home settings, travel have a more significant effect and seem remote from our personal choices. Clearly, it's complicated.

Introducing Dr. Talya Miron-Shatz 00:50

My guest, Dr. Talya Miron-Shatz, a key note speaker, consultant, and researcher at the intersection of medicine and behavioral economics wrote a book, Your Life Depends on It: What You Can Do to Make Better Choices About Your Health that was just published. She is a visiting researcher at the University of Cambridge. Dr. Miron-Shatz was Nobel Prize winner Daniel Kahneman's post-doc at Princeton University, and a lecturer at Wharton, the University of Pennsylvania. She is CEO of CureMyWay, an international health consulting firm whose clients include Johnson & Johnson, Pfizer, and Samsung.

Health Hats: Thanks for joining me. It's lovely to see you. And I appreciate that you're on the other side of the world. I think it's amazing that I saw you not that long ago.

Talya Miron Shatz: Yeah. It was fun. It was such a fun time being at the health conference, and it's almost like we got so used to zoom, and you think you don't need to see people in person, and then you see them in person. It's great.

Health Hats: It is great. All right. So, thanks for joining me, joining us. I've been looking forward to this conversation for months. I love your book. Your life depends on it. What you can do to make better choices about your health. I will put links to the book in the show notes so people can check it out. I'd like to start with, when did you first realize that health was fragile?

Talya Miron Shatz: I think if I can go politician on you, Danny, and just change the question, I guess for me, I always realized health was fragile because my mom had huge eye problems when I was like in sixth or seventh grade. No, when I was six or seven, not in sixth or seventh grade, I was little, and she was slowly getting cataracts and could barely see. Then she had an operation. She was very fragile. Like she could only walk around very slowly. And at the same time, there was a movie about a woman going blind. So, I would practice, I had been blind, like just in case, can it seem to very tangible option? So that's about fragility and vulnerability, but I guess the way I want it to change the question is to change it to what I do. And I'm a psychology professor, and I studied medical decision-making. So, I'm a full professor in Israel. I'm a visiting researcher with the University of Cambridge. There's a lot of research that I do. And I work with companies and startups, pharma and advertisers, and whatnot on medical decision-making.

Genetic counseling and medical decision-making 04:27

Talya Miron Shatz: But the reason why I found medical decision-making so fascinating was that I sat in on a genetic consultation. So, it wasn't mine. I was just sitting in because I was invited to teach at the medical school to teach genetic counseling students. I was a Ph.D. student at the time, and I said, okay, but I already have three kids, and I never had genetic counseling. What does it look like? And I sat in on a consultation. So, on one side of the table was a great genetic counselor with who I'm still friends. Like I spoke to her today. It's maybe 17 years after that first encounter. And she's great. She's very smart. She's very knowledgeable, and she's very personable, patient, compassionate, everything perfect. On the other side of the table was a couple who couldn't hear well. They couldn't hear at all. And they had an interpreter with them, and they had her little boy with, and it was a small room, and it was crowded. Even more, crowded when we started talking about genes and chromosomes. It became packed, and I could see that it was puzzled and hadn't left me. The way that you can have the best professional with the best intentions and the most knowledge and the most patients and people who need to listen and understand and process what they're being told under less-than-ideal circumstances because they come to ask about their pregnancy, and they have questions. And it's loaded with emotions, and they didn't even have a decision to make. They just needed the information. And when they left, I thought, what would they remember? What will they make of it when their family asks? So, what do they say? What does she say? What will they know? And that's when I understood that it's just difficult, even under the best of circumstances, and we don't always benefit from the best circumstance.

Personal goals, exploration, universal truths, and decision-making 06:52

Health Hats: Yeah. When I think about decision-making for myself and my health, I think about what I want from life. First, do you think that perception that I have is true, and how can that be easier? And in my experience, that's a tricky question for people to answer and not just lay people, everybody, professionals as well, doctors, nurses. It doesn't seem like it's a way people often think, or there are

large groups of people that, that is a foreign way for people to think, what do they want from life? But if it's true, that's an important part of making decisions.

Talya Miron Shatz: My, you have big questions. I think it's true for you. I think it's very true for you. I believe some things are universally true, and I will fight for them. And one of these things is that people should receive information that they can understand. This is universally true. Okay. Now they can decide. They can say I don't care about your stupid information. And that's fine because that's how they want to decide. They can say that I will read the New England Journal of Medicine article, and I don't need your information. They can do whatever they want, but they should be served information that is understandable and makes sense to them that they have enough time to decide. That's those things. That's universal for me. That is crucial. I'm a psychologist. I have a Ph.D. in psychology, not a therapist. I studied decision-making. So, when people spoke to me about ethics, I would say no, that's really outside my realm. But then I realized medical decision-making is riddled with ethical choices. I choose. And my choice is that I'm talking about how people should be served information and what decision processes should look like, but not the outcome. Now how anyone constructs the decision-making process is up to them. You have a very interesting way of doing it, which is true for you. Some people will be stumped when you ask them, what's important for you in life? They'll say I don't know my family, my health, making enough money, watching a game, having a beer, it runs the gamut. And I just did a study with leukemia patients and their caregivers. So, some of the patients were acute, had acute leukemia. Others had chronic leukemia, and you could see that between them and their caregivers in terms of what's important and how much money should we spend on treatments? And should we always continue regardless of outcomes, et cetera? So, it seems that there is no answer. And that the answer might shift for people at certain points in their lives. But I think one thing that is also universally true and I'm adamant that people should decide however they want. So, I have a paper that's one of my best-selling papers, which of course, I don't get any money for. But it's about deliberate. It's a scale that I built with Dr. Glyn Elwyn from Dartmouth. He's an MD, one of the biggest names in shared decision-making. And we built the scale to rate the deliberation process, as in, how are people thinking, how are they making a choice? And we completely removed the outcome from the equation. I don't care what you choose because maybe you chose something I would never choose. And who cares because you're not me. And maybe you chose the dumbest thing in my mind, or your doctor says, what are you doing? This is it doesn't make sense, but it works out. Or maybe you choose the right kind of surgery, and it's perfect with God forbid it gets infected. Let's take the outcome out of the equation, and let's just have a good decision-making process, and anyone can choose any whichever way they want because, thankfully, it's still a free country, though. The only thing is you must bear the consequences, and you should know what the consequences are.

Consequences, risks, benefits, and alternatives 11:22

Health Hats: Consequences. Yeah. The consequences. There are the consequences that are physical mental, and then there are life consequences. So, when a clinician collaborates with somebody making decisions about their health or medical care. How prepared are clinicians to understand what might be consequences? I'm like drawing a parallel or a line between them. People should be that people should receive information about their choices in a way that they can understand. And if part of making the

choices are consequences expected and unexpected, the. The professional will understand consequences that are physical, mental, behavioral, but not life for that person.

Talya Miron Shatz: What do you mean by life

Health Hats: Meaning childcare, transportation, keeping their job, their marriage, other priorities to them, other important things in their lives. So, consequences aren't just unintended, physical and mental consequences, but there are other consequences. That's a hard conversation to have when you're not familiar with the person's culture or environment. Am I making sense?

Talya Miron Shatz: You are. Yes. I think these are two very different perspectives. The professional's perspective will be to say, for example, that I'm thinking about knee surgery because a friend of mine was supposed to have knee surgery. And she said, she asked the set of questions, and I'll get to your answer in a minute. I'm not dodging it. It's a long-winded way of getting. It's an important question. She asked a set of questions that I always recommend asking. I called them to ask about what matters, and those are, what are the risks? What are the benefits, how many people will enjoy the benefits, and the alternatives? And the risk was you're going to be immobile for six weeks. What are the benefits? You will have a repaired knee, which happens for about 50% of people. Not amazing, but that's what we've got and what are the alternatives? And we talk a lot about patient empowerment, and I think people can be empowered simply by knowing that it is fine to ask about alternatives. It's not disrespectful. It's within your realm. It's within your permission, if you will. It doesn't undermine the doctor's authority. And apparently, she learned that the old alternative was physical theater. Standard physical therapy, difficult physical therapy, which the doctor said most people just couldn't stick with it. It's too hard for them. And she said I'm not most people. And she isn't. She's like she did it. By asking about an alternative to surgery and learning that it was physical therapy, she could say, this is what I choose. Now the doctors don’t know her. So, the doctor doesn't know that being immobile is torture for her being immobile means not going to yoga because she adores yoga. The doctor doesn't know that, but he gave her enough information to tell that she could do it. And the doctor doesn't know that she has a car or that she's a university professor. So, she has a lot of flexibility with her. She doesn't have small children. So, it's fine for her to go to physical therapy. She doesn't have to be in a factory from 7:00 AM till 7:00 PM and then takes two buses home. The doctor doesn't know that he gave her enough information to make the implications. And for someone else, the same information could have led to a completely different conclusion, but she had enough to go by to do this translation for herself and say, this is what it means.

Decisions with family caregivers 16:21

Health Hats: Okay. I want to pull a different thread from a few minutes ago about the family caregiver and their role in decision-making. And it seems to me that the role can either be helpful or complicated or both. So, when you do your studying of decision-making, how do you figure in, or how do you deal with the factor of the family care partner or whatever you want to call it. Somebody who influences the decision or is impacted by the decision in their lives. Not just the person who's not feeling well.

Talya Miron Shatz: I think it's a very important, even crucial, often grueling role, the caregiver role. I did one study with caregivers, but I'll talk about it more in the context of the end of life in a minute. So, the study I did was with leukemia patients and their caregivers. And you could see the priorities were a little bit different. You could see that with the acute patients more than with the chronic patients. There was an understanding that both the patient and the caregiver have a role, have a meaningful role where the family has a meaningful role in decision-making. It's not something that people do alone. In fact, a lot of the workaround shared decision-making involves a dyad of the person and the doctor, but the person often doesn't come there alone. And you're talking about consequences. The consequences apply to the patient but also to the caregiver. Going back to my friend. If she's immobile, will someone be able to do the grocery shopping, deliver or cook, or if there are small children, take care of them or drive her around? These are things where the patient can make a choice, and it also influences other people. So that's not just a dyad. That's the person, the caregiver, and there are ripples. There are multiple ripples. And that needs to be considered. I think in the context, for example, in the context of, and that epitomizes end-of-life conversations. It seems that everyone avoids stepping on everyone else's toes, just having these conversations, like the plague. And when I give talks, they sometimes say, you have something to say to you, and I'm sorry, but that's, we're all going to die. And that's a fact, but which we don't like to talk about. and of all things when people are sick and when people have a poor diagnosis, their family doesn't want to talk to them about it is if not talking, we'll just push away any grim events that might happen? The patients don't want to talk about it because it depresses their families. So, everyone is worried about not just everyone else's health but also about their emotions. And that's hard to just one demonstration of what it's like to be both a patient and a caregiver. And the fact that many patients don't just care about themselves and getting better. They also care about the people who care for them because they love them. They appreciate them. So, it's complicated. As you said, it is multiple things. Yeah, it is multiple things, I think, to not acknowledge that is to pretend. And I don't like pretending. We are often pushed towards a rosy prospect of things in health, and I'm an optimist, but I'm also a realist. I don't like to live under any kind of tyranny. Also, the tyranny of positive thinking. Sometimes it's fine to say I feel bad it sucks.

Cost of decisions 20:37

Health Hats: It sucks. Yeah. So, another complicated feature of decision-making is the cost, like monetary cost. And there are different kinds of monetary costs, and for people, it's an out-of-pocket expense. Back to the caregiver, it's the cost of the caregiver's career or the caregiver's health or the cost of transportation, the cost of whatever. When you are studying this studying decision-making how does the variation and people's willingness, comfort with, understanding of cost, whether they're the doctor, the patient, the caregiver, how does that figure in when people are making decisions, have you found in your work?

Talya Miron Shatz: So, I'm giving a talk at a business school in two days, and I'll be talking about fertility treatments and the cost thereof. And I'm talking about them in a place where treatments are presumably free, and they are free, not just presumably free. There's a lot of complementary medicine and sperm donations and private consultations, and a lot of money is involved. And that's one of the only studies where I asked women because I was studying women about their stopping rule. After all,

they studied women from age 43 to 45. That's an age where your prospects are not very good for fertility treatments. And I asked them a bunch of questions about information, et cetera. And I also asked how much money did you spend so far? And is there a limit to the amount of money you're willing to spend? And then, you go in. It's to make a very crass comparison. You go to the mall; you don't just bring all your credit cards; I hope and say I'm just going to spend until the mall closes. You say, yeah, I'm going Christmas shopping. It's almost Christmas. I want to spend $300 on presents or five or whatever limit you set. But going into fertility treatments, we asked them, is there a limit? Nope. Half of them said I didn't think about it. Wow. And yeah. And the other half said, no, there's no limit. And they had spent

Health Hats: Half said there is no limit, and half said they didn't think about it?

Talya Miron Shatz: Yes. Wow. Wow. I know what the finding is. It's very similar to, is there a limit to the number of IVF cycles you're willing to have? I didn't think about it or no; there was no limit. Now, these things are torturous. It's not fun. And yet they continue. So herewith the money, they did not set a limit. And I have a hypothesis. What happened with the fertility treatment is Nobel prize winner Richard Thaler, who defined and created behavioral economics; he calls it sacred values. So sacred values are things that you can't put a dollar sign-on. And I'll give a sports example. You root for the Rangers, and then they lose. If you had any sense, you would stop rooting for them; you would start rooting for the winning team. But no, you go home super bummed. Now, what is up with that? The reason is that whatever team is the Rangers or the Knicks or whoever you're for, that's a sacred value for you. It's not fungible. You can't replace them with anything else. You're not going to any calculation now of what is better, you say, they're my team for better and worse. And with fertility treatments, the sacred value is I want to have a baby, and it's going to be expensive. I don't care. Why are you talking to me about money? I don't care about money. I want to have a baby. In these contexts, and the context of cancer care, et cetera, people don't think about money at all. But they believe that in other domains, they do. And over time, they do. And sometimes, at the beginning of a medical condition, they take the approach of I'll do whatever, and I'll spend whatever. And sometimes, they realize that the fact that they're not calculating is not sustainable, and they must make changes, but it's not the first thing that comes to mind.

Health Hats: I know I think about not wanting to be a burden to my family. So that burden can be how much care I need, personal care, and what we can afford. One of the infusions I have is it's a hundred thousand dollars a dose and how, yeah. At one point, I had to pay $75, and the insurance paid the rest, and then it changed to, it would cost me 20%. That was a copay of 20%. And I was like forget it. There's no way I forget it because there was no way we could have afforded it, but still, even if it was less, there's a limit because then, there'd be, I'd have to borrow money from people. My wife might end up being in debt, so there are those factors.

Talya Miron Shatz: Can I just say something about the example. I think between $75 and $20,000. Yeah. It's obvious. That $20,000 is prohibitive. It's also not lifesaving. It's not like you have to take it right now. It's like you're allergic to bees, and the epinephrine shot is $20,000, and without it, the person's going to. You would spend that money.

Health Hats: Yes.

Talya Miron Shatz: It's like it's clear cut. And those situations, it's clear cut. It's the in-betweens that are more complicated. And I think you made a very good point before with the career, caregiving burden, et cetera. These things don't always come with a dollar. It's a behind-the-scenes dollar sign. You don't see it. Nobody says for today's caregiving session; you have to pay. I helped my mom. She has a caregiver who has Sunday off. So, on Sundays, I'm on shower duty. I must stand by my mom, and she takes a shower, and then I put her robe on, and she's cute. And I sit with her and whatever. So, these are two hours when I'm not working. I don't charge my mom, not crazy or nasty. I would do anything for my mom. But what if I had to give up work for that as it happens? I'm an academic; I didn't teach at that time. It's fine. What if you have to get off work? What if it's even more subtle in that you don't take the better earning job. Cause it's less flexible. It's hard to put the dollars, and that is hard.

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COVID, vacation, depression 28:48

Talya Miron Shatz: And I'm glad you mentioned vacation, and I'm going to connect this with COVID. How about that? So, we all know. And mostly when COVID started, we all knew how many people died of COVID. How many people had COVID, how many were in the hospital with COVID, and what we never saw on TV was how many people were depressed because of COVID, right? Felt locked at home. They missed their family, or just couldn't go out or were at home in problematic family situations; those are costs to mental health that occurred. Yeah, in a big way. If you read the studies, young people who had suicidal thoughts reverted to drug abuse, substance abuse, alcohol, et cetera. And you didn't see that on TV. You couldn't count that, but it was there. And that's something to consider when someone doesn't take a vacation because they don't have the money or they're caregiving, et cetera it has an effect.

Tracking decisions and outcomes over time 29:52

Health Hats: Yeah. And so, it's hard. I guess the reason I bring it up is that. The whole thesis, it seems of this conversation, is that decision-making is complicated, and it's complicated with the stuff, and it's complicated with the stuff you don't know. Anyway, I want to hit one more topic. So, I want to get into it. So, you and I have had this preliminary conversation. So let me introduce it briefly for our listeners and readers. We are always making decisions about our health, and we make decisions, and we could decide to do a, B, C, D E, or to do nothing, which is a decision. And when scientists study decision-making, it seems that they're studying it in somewhat limited circumstances, whether it's the populations, the settings, the timeframe. And I just have this niggling for years. If we say in a study that a is more likely to be effective than B. And so, then that becomes part of a clinical guideline. It becomes

part of the culture of recommendations or the regulations, but we don't keep saying well, does it? No matter what, nothing is absolute; it works for some, it's true for some people, and it's not true for others, but we don't do that. Longitudinal, let's keep seeing here's a decision was made. Now let's keep tracking outcomes as more and more people make those decisions. So, from your point of view, as a decision scientist what do you think about that idea of keeping on studying it and continually learning the outcomes of decisions?

Talya Miron Shatz: I think it's a wonderful idea. I think it's done. In some places, it's done. So, Israel, for example, is one place where it happens. Not because they're keen on studying, just because everyone has a unique identifier. People stay with their HMOs for decades. You're incredibly unlikely to switch an HMO in Israel if you switch once it's okay. If you switch twice. It's what is wrong with this person? They're flaky. You can't trust them. So, you stay with your HMO for decades. They have a lot of information about you. They know everything; they know your blood work. They can track that. So, they can do longitudinal studies using big data because they have the big data, and that's yes. That's the bright side of it. So, you talk about decisions, and that's where it gets a little murky. So basically, I can say that out of a hundred thousand people who have prescribed something, I'd say atrial fibrillation is a scenario that I worked on a lot. So, a hundred thousand people were prescribed medication. They persisted with it for an X amount of time. And how do we know that they persisted because they kept filling their prescriptions? Now, I don't know if they filled their prescription and gave them medication to their lover or never took it. I don't know where it took. I just skipped the weekends because they didn't feel like it. I have no idea. So, I might; my knowledge is limited. And in one of my webinars, the head of health in IBM Research participated. She was in the audience when someone asked the question, and I said, you are better equipped to answer it. Why don't you? And she said we don't know the behavioral factors. So, if you're talking about these hundred thousand people, did they adhere to their medication? We know, but we know.

Health Hats: It's a proxy

Talya Miron Shatz: Precisely. And I don't know much about their lifestyle. It's not necessarily captured. Do they exercise a day, not exercise? What do they eat? How high is their stress level? So, a lot of information is just not captured and will probably never be captured, at least not in a centralized way.

Health Hats: That's for Israel, where there's some central data. As opposed to the United States, where everything is just incredibly fragmented. Yes.

Talya Miron Shatz: Exactly. And there was a study where they wanted to recruit a million people. They probably did attract their health. That's great, but that's a million people out of 315 million Americans. It's less than 1%, and the rarer the condition, the less likely you are to find a person with that condition and that data set. And it's also volunteer. You have to volunteer the information as opposed to people, just researchers, just going in a de-identified manner and reading my health record and saying, oh, this woman has been on this since then. And whatever. And that's just an easier way to collect data, and

that's, it connects with everything. It connects with how doctors need to build information systems because doctors like to save cognitive effort. It connects with how digital health needs to be served to people. To users, the easier, the seamless, the better, ideally with some emotional component that motivates them. That's something that I've been doing for a very long time. And I don't think the need for this will go away anytime soon. So, if it's easy, it will be captured and used if it's seamless better. And if not, it's going to be difficult.

Action, implementation, rather than a new study 35:54

Health Hats: Okay. What you're saying is discouraging because I have this idealistic pipe dream even in the best of circumstances. It's way complicated. But suppose you were to think about the germ of possibility in this complicated, unlikely whatever this is. In that case, I'm proposing what is if I wanted to hook on something smaller and more possible that would have value to people who make decisions. Like, better understanding the disparities or whatever, I don't know. What's a germ of possibility in this?

Talya Miron Shatz: I think there's already a lot of knowledge. Since you mentioned disparities, I'm doing a webinar on disparities. It doesn't sound like it's on disparities, but it is because we call it, and I'm doing with someone from Humana, an MD from Humana, Z Colette Edwards and we call it, Why Can't They Just Ask? And that's about health disparities. It's about less-educated people and those from a lower socioeconomic status. And they're less likely to ask their doctor questions. The doctor says something, they say, okay, because they don't want to feel dumb. They don't want to admit that they don't know. And you know what, it's fine not to know. Not everybody knows everything. And you have the right to understand, even if you only finished elementary. It doesn't matter, you're a person, and you deserve to be healthy and informed. So, they don't feel that they have this right. They don't think it's culturally appropriate for them to ask the doctor questions to waste their time. God forbid undermining their authority. So that's a disparity. And you know what, Danny, it exists. We know that. We don't need to run another study. And that's the one reason I wrote my book, Your Life Depends on It. What you can do to make better choices about your health is because I figured there are many studies. Many things have already been studied, and we know the answer. What we're not doing, though, is implementing the solution. Yeah, that's where I wanted to be. I tried to put the knowledge out there. So, I don't think we need to do more studies on health disparities. We need to take existing knowledge and say, here's what happens. It's not great. Not because I'm goody two shoes, and I want to pretend like I'm a nice person. But because this is hurting people's health, it's hurting the economy. It's hurting ROI for health organizations, health care organizations, employers; that's a lose-lose long, long chain of losses. So, let's make a difference with the knowledge we already have. There's plenty of it.

Top three takeaways 39:03

Health Hats: That's so interesting. Okay. Let's wrap up, and let's wrap up with pick one. What should we have talked about that we didn't, or what do you think the three most important takeaways have been in this conversation?

Talya Miron Shatz: One is that making health decisions is complicated, and it's complicated for everyone. That's all, that's a health decision—another takeaway. The health decisions don't just happen between patients and their doctors, but rather a larger circle. And a third is that there is a lot of knowledge out there waiting to be implemented by healthcare executives, medical associations, et cetera. And, by patients. Show me not just a patient, a person. A person who doesn't know that smoking is bad and physical activity is good. You'd be hard-pressed to find such a person right now. Does everyone who knows that act upon it? I don't think so. So not knowing is not enough. We need motivation, and we need facilitation. We need all these things. So yeah. You said it was discouraging. It's just realistic. You don't have to study physical activity to know that it's good or smoking, et cetera, alcohol abuse. It's just really complicated. The way people behave. They don't always behave in ways that are optimal for their health. They're maximizing are their utilities are fine, to speak the behavioral economics lingo, or they just can't do better by themselves, which is a shame. And that is a space where I think health and digital health still needs to grow. We are not there yet. We're amazed by medical knowledge; we're amazing with technology. We're not amazing with the behavioral stuff. Not yet.

Health Hats: If anything, we might be taking some steps back. Thank you. Thank you. I love talking to you; what a great opportunity this is

Talya Miron Shatz: fantastic.

Health Hats: Thank you.

Talya Miron Shatz: Take care, Danny. Bye-bye.

Reflection 41:22

When tackling something complex like medical/health decision-making you can occasionally see sunlight while also find yourself deeper in a thicket. I feel that way now. Where do I see sunlight? People should receive information they can understand. All decisions have consequences, predictable or not, expected or not, physical, mental, spiritual, and financial. Decisions involve, affect, more than the dyad of patient and clinician. It includes family, caregivers, neighbors, and co-workers. Where am I still in a thicket? Sometimes I want to lay down and give up – it's too complicated. Sometimes the right decision seems so clear to me, has been thoroughly studied: Get exercise, get vaccinated, don't smoke. But acting on decisions or knowledge is maddeningly difficult. Don't people see what I see? Well, of course not. How arrogant of me. Decisions involve power. Power is always messy. Even Israel with a common person identifier, can't study the effects of decisions over time. I thought it would be easier. Gosh, I'm just getting started.