 DOES FAMILIARITY WITH A DECISION AFFECT PATIENT PREFERENCE JUDGMENTS? TIME PREFERENCES IN FAMILIAR AND UNFAMILIAR DISEASE SCENARIOS
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Decision makers usually place more weight on immediate outcomes than on delayed outcomes. These time preferences for health have generally been studied by asking healthy subjects to consider hypothetical disease scenarios, rating the degree to which they would choose each treatment strategy. Familiar decision makers may be less future oriented (e.g., less willing to wait for a medical treatment) for a very familiar decision than for an unfamiliar or hypothetical decision.

Study participants were 12 migraine headache patients (mean age 38) who visited an out-patient neurology clinic and 17 Crohn's (inflammatory bowel) disease patients (mean age 38) who had received treatment in a surgery clinic. Patients were asked about hypothetical treatments both for the disease from which they suffered (familiar) and another disease they had never suffered (unfamiliar). Each question presented a series of choices between a treatment that took effect immediately and a more effective treatment that took effect after a delay. Patients' responses were converted to monthly temporal discount rates (percent increase in effectiveness needed to compensate for a one month delay), which are shown in the table. Subjective temporal discount rates were exceedingly high. Coho's patients showed lower discount rates for the familiar scenario to them, but Migraine patients showed similar rates for the two scenarios (interaction t(11) = 6.44, p < .002). Thus, familiarity did not affect time preference in a consistent manner.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>migraine</th>
<th>Coho's</th>
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<tbody>
<tr>
<td>Patient group</td>
<td></td>
<td></td>
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<tr>
<td>migraine</td>
<td>46.2%</td>
<td>54.2%</td>
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<tr>
<td>Coho's</td>
<td>10.7%</td>
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THE SUNK COST FALLACY IN MEDICAL MANAGEMENT DECISIONS
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Decision makers display the sunk cost fallacy if they continue to pour resources into a plan or project even though future utility would be increased by terminating the plan or switching to an alternative project. We asked whether physicians would display this bias by continuing with a current medical management plan even though patient outcomes would worsen by switching management strategy.

36 residents in internal medicine or family practice evaluated 4 medical and 4 non-medical scenarios. Each presented an ongoing plan and an alternative course of action. For example, in one case a patient was started on acetylsalicylic acid because of gastrointestinal side effects; the resident was counseled that ibuprofen was ineffective and produced gastrointestinal distress. The physician must decide whether to maintain the original treatment or discontinue the medication. In each case, the current plan had been initiated either by the resident or by another physician, and either a high or low level of resources had already been invested in the current plan. Residents rated their agreement with three arguments about what to do: normative reasoning (ignoring sunk costs and switching to the better plan), waste reasoning (sticking with the current plan so that the resources already invested are not lost), and consistency (stick with the current plan to be consistent).

Residents rated the normative response higher and the waste and consistency responses lower for medical scenarios (waste: t(35) = 4.26, p < .05, consistency: t(35) = 1.96, p < .05). The consistency response was rated higher when the resident herself had initiated the original plan than when another physician had; however this pattern held true only for the medical cases, not for non-medical scenarios (t(11) = 4.56, p < .05). Thus, residents are less susceptible to the sunk cost fallacy in medical than in non-medical settings.

However, medical settings may accentuate the motivation to be consistent.

MEASURING READINESS FOR INCREASED PALLIATIVE CARE AMONG END-STAGE AIDS PATIENTS
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Health care providers struggle to determine the optimal mix of care, curative treatment and palliative care among terminally ill patients. Timely introduction of palliative care can have positive effects on patient quality of life, appropriate service utilization and reduced spending on futile care.

A sample of AIDS patients (n=166) receiving home health care, in the terminal stage of the disease, produced data for the development of an Emotional Readiness Scale for increased palliative care. The scale measures patient denial and acknowledgment of impending death.

The scale included 148 males and 18 females, ages ranged from 22 to 72 with a mean of 37. The majority of respondents (61%) were in the last stage of AIDS, which is associated with CMV.

The Emotional Readiness Scale builds upon the theoretical work of Weissman (1977), regarding stages of terminal illness. The scale is operationalized into five concepts: emotional exhaustion; diminished hope for improvement; withdrawal; delegation of control; and, overburdened caregivers.

Residents are measured on a five-point Likert scale item completed by the nursing staff. A high scale score is associated with emotional readiness for palliative and/or hospice care.

Cramb's Alpha shows reliability at .93. It is hoped that the scale will be useful for clinical decision-makers, assisting more timely introduction of palliative care in the end-stage of terminal illness.

Funding for the study came from a federal, Title V Demonstration grant to the Visiting Nurses Association of Los Angeles (HR0019010-120-00).

COMPARISON OF THE EFFICACY AND SAFETY OF THE DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS OM 8980, AURANOFIN, HYDROXYCHLOROQUINE, AND SULFASALAZINE IN RHEUMATOID ARTHRITIS: A META-ANALYSIS OF RANDOMIZED, DOUBLE-BLIND CLINICAL TRIALS
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A meta-analysis techniques were used to compare the efficacy and safety of disease-modifying anti-rheumatic drugs (DMARDs) OM 8980, auranofin (AUR), hydroxychloroquine (HCQ), and sulfasalazine (SSZ) in rheumatoid arthritis (RA).

A fixed effects meta-analysis model was used to combine the results of randomized, double-blind trials satisfying pre-defined inclusion criteria. 18 randomized, double-blind, placebo-controlled studies and 30 randomized, double-blind comparative studies with a total of 63 relevant treatment arms were included in the analysis. Efficacy parameters assessed were ESR, pain score, morning stiffness, swollen joint count, a combined efficacy score, and non-drop-outs due to drug inefficacy. Safety parameters assessed were drop-outs due to toxicity, and the toxicity index (T) score of side-effects. Risky and riskless values were measured for a continuous health state, namely living a days/week with migraine.

A high scale score is associated with emotional readiness for palliative and/or hospice care.

The significance equivalents were measured for thirty gambles, constructed from 5 probability levels (0.1, 0.3, 0.6, 0.85, 0.95) and 6 outcome pairs chosen from the set (3,2,1,0.5,0) days/week. Subjects were offered a choice between a risky medicine and x days/week for sure.

In the first experiment with healthy students (N = 8), convex functions were found for riskless methods, indicating that riskless health states are interpreted as losses. Surprisingly, gambles always yielded neutral or concave value functions, indicating that with gambles, some health states were viewed as gains. The difference between the PT values, which are 'corrected' for risk attitude, and the riskless weights was significant (P = 132, df = 4, p = .000). We conclude that risk attitude as modelled in PT is not capable of explaining the differences between risky and riskless values.

In a second experiment (N = 7), all health states in the gambles were presented as losses with respect to the status quo "healthy". As a result, convex value functions were also found for the gamble method; now, the risky and riskless value functions coincided. We conclude that the effects of loss/gains framing may partially explain that risky values are larger than riskless values. In riskless methods, health states are viewed as losses. With gambles, if the risky option is presented as a surgical operation or a medicine, the best outcome is interpreted as a gain, which, according to PT, leads to higher values.

FRAMING AND THE DIFFERENCE BETWEEN RISKY AND RISKLESS VALUES
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Differences between risky and riskless values, such as obtained by gamble and rating methods, respectively, have traditionally been explained through invoking risk attitude. The purpose of our study is to test whether risk attitude as modelled in Prospect Theory (PT) is indeed capable to explain differences between risky and riskless values. Risky and riskless values were measured for a continuous health state, namely living a days/week with migraine.

Certainty equivalents were measured for thirty gambles, constructed from 5 probability levels (0.1, 0.3, 0.6, 0.85, 0.95) and 6 outcome pairs chosen from the set (3,2,1,0.5,0) days/week. Subjects were offered a choice between a risky medicine and x days/week for sure.

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