

SOUNDING BOARD

Harnessing the Power of Default Options to Improve Health Care

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When making many types of decisions, people are confronted with default options — the events or conditions that will be set in place if no alternatives are actively chosen. Because default options are implemented even if decision makers do not actively choose them, they hold a privileged status among all possible choices.

Default options strongly influence behaviors in settings that are not related to health care. For instance, employees more frequently contribute to retirement funds in an automatic-enrollment system than they do in systems that require active participation.¹ Drivers' preferences for a high tort-insurance option increase when it is offered within the default insurance policy.² Also, the proportion of Internet users who are willing to be recontacted by marketing Web sites increases when users are permitted to opt out of further contact rather than asked to opt in.³

The influence of default options has also been observed in at least two health care settings: employees' contributions to health care flexible-spending accounts, which are largely determined by default options,⁴ and organ donation, for which the change from opt-in to opt-out policies has increased donation rates in many European nations.^{5,6} However, default options may affect a far broader range of health care decisions than many people generally recognize.

Recently, health care experts have proposed policies that actively manipulate default options. The Centers for Disease Control and Prevention has recommended that physicians test all patients for HIV as part of routine care unless patients specifically choose not to be tested.⁷ Leaders in critical care medicine have proposed that all Americans be notified that they may join a registry of persons who have chosen to opt out of emergency research, with the implication that those who do not opt out agree to participate in such research if they become eligible to do so in

the future.⁸ The Infectious Diseases Society of America is urging Congress to mandate annual influenza vaccination for all health care workers who do not specifically decline vaccination in writing.⁹

These policies aim to influence people's choices in predictable ways without restricting their options. In this article, we suggest default options that may rapidly improve the quality of health care. We also consider the goals and ethics of default setting and provide principles to guide policymakers in setting future default options.

DEFAULT OPTIONS TO IMPROVE HEALTH CARE

Default options may be set to serve several health care goals: to promote the use of interventions that improve health care, to reduce the use of interventions that place patients at risk, and to serve broader social agendas such as cost containment. For example, an opt-out policy of routine pneumococcal vaccination of hospitalized patients might increase the number of patients who receive this useful intervention. A policy to remove indwelling urinary catheters after 72 hours unless physicians or nurses document a reason for maintaining them could reduce the incidence of nosocomial infections.¹⁰ The familiar policy whereby drug prescriptions default to generic medications unless physicians check a "brand necessary" box promotes the social goal of decreasing health care expenditures. Table 1 includes examples of default options that could be readily and broadly implemented to improve the quality of health care.

These default policies are easily implemented, are unlikely to be controversial, and might substantially advance health care quality. Others may present more challenges. For example, recently an Institute of Medicine (IOM) committee recommended against changing the American organ-

Table 1. Examples of Default Policies That May Improve Health Care Quality.

Policy	Supportive Data
In outpatient settings	
Routine HIV testing for all patients not recently tested unless they opt out	Branson et al. ⁷
Automatic delivery of pharmaceutical prescriptions unless the physician opts out (not applicable to Drug Enforcement Agency–controlled medications)	—*
In inpatient settings	
Annual influenza vaccination for all health care workers as a condition of employment unless they opt out in writing	Schnirring ⁹
Routine pneumococcal vaccination of all hospitalized patients for whom it is indicated as a condition of discharge, unless patients opt out	Department of Health and Human Services, ¹¹ Centers for Disease Control and Prevention ¹²
Removal of all urinary catheters after 72 hours unless a nurse or physician documents in the chart why a catheter should be retained	Cornea et al. ¹⁰
In intensive care units	
Routine ventilation of all newly intubated patients with lung-protective settings unless or until other settings are ordered	The Acute Respiratory Distress Syndrome Network, ¹³ Gajic et al. ¹⁴
Adjusting the heads of all beds to a 30-to-45-degree incline unless a physician indicates otherwise (e.g., for patients with hypotension or after cardiac catheterization)	Drakulovic et al., ¹⁵ Kollef ¹⁶
Daily interruption of sedative infusions for all mechanically ventilated patients in the ICU unless otherwise indicated by a physician	Kress et al. ¹⁷

* A possible policy; no supportive data are available.

donation policy to an opt-out system because committee members perceived insufficient social support for such a change.¹⁸ To properly consider such potentially controversial default options requires an understanding of how they influence behavior and of the ethical issues involved in intentionally setting them.

THE GENTLE INFLUENCE OF DEFAULT OPTIONS

The hallmark of default options is that they influence decisions without restricting choice.^{19,20} Given that choice is preserved, one might be surprised by how influential default options are.¹⁻⁶ These options influence behavior because of well-described pitfalls of human decision making such as status quo bias, or an aversion to change, and omission bias, or a greater fear of errors of commission (choosing a bad option) than of similar errors of omission (not choosing a better option).^{21,22}

Other factors may determine the magnitude of a default option's influence in specific settings. First, default options exert stronger effects on the many choices about which people lack strong

preferences to guide their decisions.²³ In such circumstances, complacency or inattention may lead people to accept the first choice presented. By contrast, default options are less persuasive when people have established, contrary preferences. For example, on the whole, Americans prefer low-deductible health insurance.²⁴ Perhaps for this reason, 78% of Medicare beneficiaries who enrolled in Part D selected plans with no deductible, even though the Centers for Medicare and Medicaid Services set a \$250 deductible as the "standard benefit."²⁵

Second, because people may interpret the default option as a recommendation or guideline,² contextual factors such as trust in the person or persons who established the default option may affect the degree of its influence. For example, families of critically ill patients may more commonly choose to withhold invasive therapies at the end of life when this choice is framed as the default option by a physician who has long cared for the patient than when identical framing is used by the physician's colleague who is covering the patient's care for the weekend.

Third, the influence of default options increases when practical barriers to switching from this

option exist. Such barriers include having to complete forms, obtain referrals, or search for an obscured option, and they are particularly strong when people are unaware of opportunities to choose. The IOM committee was appropriately concerned that Americans might not be uniformly notified of the ability to opt out of organ donation.¹⁸ These tangible barriers to choice erode the voluntary aspect of typical default options, making them more coercive and less morally acceptable.

THE GOALS AND ETHICS OF DEFAULT OPTIONS

Given the predictable influences of default options, some people may believe that setting them is unethical and represents a return to the paternalistic practices that formerly dominated medicine. However, default options are frequently unavoidable. Oncologists must decide what to do if a patient without an advanced directive has a cardiac arrest, emergency medicine physicians must have a policy for how to care for uninsured patients who require urgent attention, and cardiologists must decide the order in which they will present medical and surgical treatment options to patients with valvular heart disease. When default options are unavoidable, it makes little sense to consider whether setting them is unethical. Instead, we must ask which one of the many possible default options is most justifiable.

Too often, default options are set on the basis of convenience or natural ordering, rather than by careful consideration of their consequences. Considering the different options and setting the default option to manipulate behavior and promote the welfare of patients or society are inherently paternalistic practices. However, either a default option is set to influence choice or it is removed, thereby forcing people to choose even if they are unprepared to do so.²⁰ Because both approaches influence behavior,²⁶ purposefully setting default options is no more paternalistic than taking a *laissez-faire* approach. Rather, the difference is that whereas setting default options explicitly aims to maximize welfare, ignoring default options leaves welfare to chance.

The way in which default options are selected may determine whose welfare is promoted. In general, default options that promote the welfare of individual patients or society will be more morally acceptable than those that aim to maxi-

mize the welfare of the person or persons setting them. For example, we believe that physicians should assume, by default, that incompetent, critically ill patients want to be tested for HIV if doing so will aid in diagnosis or management.²⁷ By contrast, many health care systems have separated previously bundled chemistry panels so that specific electrolyte values are no longer obtained unless they are ordered separately. Although this choice is cost saving for the organization that sets this default option, it would become difficult to tolerate if it were found to cause substantially worse patient outcomes.

USING DEFAULT OPTIONS WISELY

DECIDING WHETHER DEFAULT OPTIONS MAY BE USEFUL

Given the power of default options to influence behavior, persons who are in the position to set them must do so wisely. Manipulating default options is particularly useful when some action clearly ought to be taken. For example, patients who have difficulty choosing between colonoscopy and sigmoidoscopy plus fecal occult-blood testing as a screen for colon cancer may end up without screening. In such cases, setting the default option to either test may ensure that some screening is performed.

By contrast, when no single decision is clearly optimal for a majority of people, or when some people are likely to be harmed by a particular default option, setting these options may be less useful than forcing people to consciously and deliberately make a decision. For example, computerized physician-order-entry systems should force physicians to actively select a specific dose for each medication ordered, rather than defaulting to the lowest or the most popular dose. The absence of a default option forces physicians to consider the most appropriate dose for each patient, and it should minimize the risks of overdosing or underdosing that these systems may generate.²⁸

ENSURING THE OPPORTUNITY TO CHOOSE

When a default option is necessary or desirable, the implementation of the default option should not preclude other choices. Occasionally, people may not realize that a decision is to be made or that choices are available to them. Because autonomy is lost when people are unaware of the

decisions confronting them, those who set default options should use conspicuous cues such as a bold font, automated prompts, or direct questioning to ensure that all people who are making the choices are directed toward the need to make a decision. For example, 15% of nursing homes in Wisconsin have policies that cardiopulmonary resuscitation (CPR) will be attempted only on an opt-in basis.²⁹ Unless all residents are notified about this choice on arrival, such policies do not protect their autonomy.

RECOGNIZING ESTABLISHED DEFAULT OPTIONS AND CONSIDERING THEIR LIKELY EFFECTS

Just as people should be alerted to the need to make decisions, those who set default options should recognize the many places in which hidden default options already exist. For example, in many intensive care units, initial ventilator settings are based on traditional or convenient values. These settings may contribute to the underuse³⁰ of specific ventilatory strategies known to reduce mortality among patients with acute lung injury.¹³ Because such low tidal-volume settings are unlikely to harm and may help¹⁴ patients without acute lung injury at the time of intubation, low tidal volumes should be used initially for everyone and then adjusted subsequently if indications arise.

Similarly, the current system that requires patients to actively fill and refill their prescriptions may undermine efforts to improve adherence to treatment. Might adherence improve if pharmacies automatically sent initial prescriptions and refills for medications that are unlikely to change frequently to patients (unless physicians or patients chose otherwise), rather than waiting for patients to fill or refill them? Empirical questions like this one ought to be asked and answered.

ACCEPTING RESPONSIBILITY FOR BAD POLICIES

The effects of default options are often foreseeable and intended. Thus, people's freedom to choose alternative options does not shield those who set default options from responsibility for adverse outcomes stemming from ill-conceived options that are flawed. For example, we advocate a policy whereby a nurse visits every hospitalized patient with an indication for pneumococcal vaccination¹² and administers the vaccine unless the patient opts out. However, if the side effects of this vaccine were unexpectedly found

to outweigh the benefits, the fact that patients remained free to decline vaccination would not defend us from blame for recommending this default policy.

CONCLUSIONS

Because people frequently lack established preferences regarding their health care choices, those in positions to set default options should use them to achieve legitimate and important health care goals. The alternative — ignoring default options — does nothing to promote choice and precludes opportunities to guide decisions in welfare-promoting ways.

Our current approach to default options in health care has itself been too passive, and opportunities exist throughout the health care system to use these options more strategically. We urge health care providers and consumers to seek out default options in their own domains of experience and to ask whether these options are serving their intended goals. Default options exist among an impressive range of decisions, from automatically selected drug doses in computerized physician-order-entry systems to whether or not critically ill patients who are too incapacitated to make decisions are presumed to want CPR. Although the ethical principles governing such diverse types of default options are similar, the public acceptability of setting default options may differ according to the presumed consequences of the selection.

Enacting policy changes by manipulating default options carries no more risk than ignoring such options that were previously set passively, and it offers far greater opportunities for benefit. Health care leaders therefore should seek more active roles in setting default options, rather than letting their own omission biases undermine otherwise favorable policies.

No potential conflict of interest relevant to this article was reported.

We thank Theodore J. Iwashyna, M.D., Ph.D., for his thoughtful comments on an earlier version of this manuscript.

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