# Patient Centricity Meets the **Science** of Behavior

Three ways behavioral science can amplify the life sciences industry's patient-centric efforts



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### Time was that healthcare decisionmaking was looked upon as a highly physician-centric activity...

In short, patients came to their healthcare providers with their ailments, doctors asked questions, probed, and ordered tests, and based on the resulting data, the doctors rendered diagnoses and recommended treatment. This way of thinking about healthcare made sense in a world in which optimal treatment selection was presumed to flow from the physician's unique expertise and the patient's contribution to the process was presumed to be secondary. It also fit the view that a treatment's clinical value should be equated with its efficacy, safety, and AE profile independent of considerations such as convenience, quality of life, or privacy - the former being information which a doctor would ostensibly be in the best position to evaluate.



### Today, though, the balance of thinking has shifted.

Where once patients were seen as willing to defer to expert medical opinion, now they are seen as **active agents who must be engaged as partners in their care.** This shift reflects a correction that has long been overdue, as new treatments have never been developed, nor current treatments been effective, without patients having the motivation and ability to participate in clinical trials, have the right interactions with healthcare providers, undergo medical procedures, and onboard and adhere to treatment regimens.



# But the shift also reflects another reality...

... one owing to a confluence of forces that have made the patient's contributions to the success of healthcare increasingly nonignorable to the healthcare system's stakeholders.

These forces, combined with soaring competition and drug development costs, have compelled life science companies to re-examine their traditional ways of doing business, driving demand for insights, strategies, and solutions that can accommodate and engage patients based on who they are from a range of clinical, functional, and psychosocial perspectives – **a movement that has come to be known as "patient-centricity".** 

- Changes in the healthcare landscape that often presume patients have the capability to navigate the system's complexities and handle even the most complex treatment self-administration tasks;
- The explosion in chronic conditions that can only be managed through the patient's own active involvement in their healthcare as it is;
- A growing consensus among regulators and experts that patient preferences must be prioritized when developing and selecting treatments;
- Cultural and technological transformations that have encouraged patients to reject the paternalistic model of healthcare in favor of shared decision-making and selfadvocacy.

# One question worth asking is whether we, as an industry, are taking full advantage of the tools available to optimize our patient-centric priorities.

As both patient advocates and life sciences leaders point out, the industry's quest for patient centricity is still very much a work in progress. Continued investment hesitancy is certainly part of it, but part is also due to our continued struggles to understand and address patients on *their* unique terms – struggles that stem from a toolkit that doesn't always align well with the hidden complexities in people's ways of thinking, feeling, and doing or with what it takes to see and act on them. These deficits can be as much an obstacle to our patient-centric efforts as lack of investment or culture-building – a problem we at Greymatter Behavioral Sciences have witnessed firsthand – resulting in blind spots that can stop us from achieving the best patient-focused insights and solutions even when the commitment to patient centricity is present.

The time is ripe, then, to weigh additional tools the industry could be deploying to better understand and take actions with patients from a fully patient-centric perspective.

### This article argues for one set of tools, anchored in the knowledge and methods of behavioral science.



# Why Behavioral Science?

Before going further, it's worth asking *why* we should turn our attention to behavioral science as something that could be useful to our patient-centric quest. The question is worth considering as agencies, suppliers, and life sciences companies themselves bring behavioral science in-house as a means of accelerating their patient insight and solutions development activities. **What is it about behavioral science that should make it valuable to achieving patient-centric ends?** 

# The answer lies, in part, with *why* it is we seek to be more patient-centric:

It's because we want to take steps in drug and trial design, brand and medical communications, patient engagement, and patient support that will more effectively activate, facilitate, or accommodate patients in their quest to change or sustain one or more aspects of their healthcare behavior – ultimately with the goal of helping them pursue, access, use, and unlock the value of the industry's innovations.

## These are all about addressing *behavioral* challenges

... whether it's in trial participation, treatment selection, treatment onboarding, and adherence, or in activities such as the consumption of digital health information or participation in productive patient-provider dialogues. Winning hearts and minds is certainly an important part of what it takes for a life sciences company to be successful in these endeavors – but, beyond that, the pathway to effective problem-solving isn't always clear. Ideas about which aspects of the patient to gain insight into, both to understand their current behavior and to figure out what to do with it, can, at times, be based more on intuition than explicit logic, and even the connections between business objectives and specific patient behaviors can become obscured.

That's why a systematic approach to analyzing and understanding patient behavior, focused on where behavior and business objectives align, can be critical to realizing the value of patient-centricity for the industry's strategic aims – **exactly what behavioral science can offer us.**  The other question, then, is *how* we should leverage behavioral science to make it the power tool we desire for accomplishing our patient-centric objectives. To note, there are many different flavors of behavioral science from which the industry can choose for this purpose. The most popular range from the idea that the science is about people's biases, habits, and the ways to nudge people to do something they might not do despite their desire to do it, to the more anthropological approach that's about listening to people's narratives, studying their behavior in their native habitats, and bringing them into the process of co-creating the solutions that will best address their thoughts, feelings, desires, and challenges.



This article sees the tools of contemporary psychological science as containing some of the best material to serve our patient-centric aims.

When used robustly, the field provides an approach that is well-acquainted with notions about biases, heuristics, nudges, habits, and System-1 processes, but also helps us go beyond these buzzwords to understand people's thoughts, feelings, and actions as the result of a complex interplay of mental, social, and behavioral processes. It listens to ideas from a broad range of disciplines to gain a sophisticated understanding of people, seeing them as agents who look to make sense of and navigate their worlds to meet a wide variety of strivings, often by relying on a complex set of skills and resources to help them act as adaptively as possible in the face of their own limitations and competing demands. It's an approach that is deeply integrative - yet that doesn't mean it's indiscriminate; it's one that sets itself apart by:

- Using structured behavioral models and theories to support rigorous, evidence-based thinking and decision-making;
- Relying on carefully selected methods to gain insight into people and determine how to accommodate, support, or change behavior –

all while providing the right tools to verify claims and solutions ideas along the way.

What results is a toolkit that:

- Casts a wide net, allowing the industry to use what's known about the social and intrapersonal aspects of thinking, feeling, motivation, and selfregulation to understand how people construe, react to, cope with, and navigate health-related experiences and engage in a broad variety of specific healthcare-relevant behaviors;
- Is adaptable, allowing the same breadth of knowledge to be applied to solutions-building for any number of specific drug development and commercialization challenges; and
- Is evidence-based, which not only gives it credibility, but allows us to see patients for who they are, and to design solutions that will be effective, because they're more closely tied to what truly describes the patient experience, drives their actions, and has been shown to work with behavior despite what everyday intuition might lead us to expect.

The benefits for the industry are multifold. Here, the focus is on three that go to the core of almost any patient-centric effort: (1) fortified empathy; (2) enhanced methods for patient insights, and (3) a lens for seeing aspects of the patient that have a way of staying stubbornly in the shadows.



# #1: Ways to Fortify Empathy

### At the heart of most patientcentric efforts is the reliance on empathy as the primary vehicle for understanding patients' experiences, needs, and values.

Life sciences companies look to walk the empathy walk by, among other things:

- Turning to market research studies, advisory board meetings, panel discussions, and workshops in which patients discuss their healthcare-related experiences and express their thoughts, feelings, and preferences regarding healthcare innovations;
- Exposing teams to immersive exercises in which team members simulate features of a condition or treatment experience as a way to walk in the patient's shoes;
- Commissioning social media listening and ethnographic projects in which the patient voice can be heard "in the wild" and the patient experience further contextualized;
- Implementing office rituals that help team members keep the learnings about the patient experience top of mind as they go about their day-to-day tasks.

### Common to these activities is the idea that we learn the most about patients when we use our native abilities to comprehend the heart and head of another person

... and that the best way to do this is to have a fleshand-blood individual in front of us into whose world we can enter by hearing their narrative, observing their daily life, and actively simulating what life is like from their point of view.

It's an approach that's well suited to the culture of the life sciences – but it also relies on our ability to empathize and take perspective effectively, where the true measure of success is how accurately we grasp another person's experiences, perceptions, thoughts, emotions, and needs, not how they reflect our own. **That's a tall order to fill.** While we may believe that we're good at grasping other people's inner lives, the reality is our empathy and perspective-taking abilities are almost always characterized by two competing truths:

- Our ability to read others' minds is powerful and miraculous;
- Our ability to read others' minds is often incomplete and biased.

It's here that a little bit of behavioral science knowledge can be of considerable use. By turning to decades' worth of published research on the psychology of everyday mindreading, we can take meaningful steps to:

- Systematically disentangle the various components of empathy;
- Identify where empathy can falter; and
- Find targeted, actionable solutions that will make more likely the empathy we seek.

Among the learnings we're able to mine from this effort are the ways empathy can not only at times be biased by our own perspective, but also quietly taxing, reserved for those who are like us, and prone to prompting actions that may be more appropriate for ourselves than for the person we wish to empathically understand.<sup>1-4</sup>



### But that same knowledge also points to steps we can take to put empathy and perspectivetaking on the right course.

As an example, behavioral experiments have shown that, while asking people in an empathy exercise to "imagine this was you" can induce an intense form of empathy that can be overly self-focused, shifting to an "imagine *you are them*" frame can make the difference in creating the separation between self and other that puts the shared emotion in its place while refocusing that experience in the context of the other person's own perspective, beliefs, and needs.<sup>5-6</sup>

Findings such as these give us direction for designing experiences that will be more likely to induce desired forms of empathy without resorting to extensive training interventions – key to making patient empathy activities feasible and scalable for life sciences professionals.

And we can turn to published research to stimulate ideas about ways to mitigate yet other empathy pitfalls – for instance, empathizing only as long as it serves our strategic purposes, causing us to disengage too early because our personal goals, once perceived satisfied, have overcome our intention to understand the other's perspective in more fully person-centric terms.<sup>7</sup> greymatter behavioral sciences



#2: Methods for Deeper Insight If empathy is what life science companies rely upon to infer what patients *think*, *feel*, *and need*, then it's their methods for capturing what patients *say and do* that provides the raw material for developing this empathic patient-centric understanding.

Among the industry's most popular methods are those that are *qualitative*, with the resulting data being patients' narratives and verbal reports about their thoughts, feelings, attitudes, behaviors, and experiences. This isn't surprising, as it's the words and expressions of a single, tangible human being, not statistics and averages, that trigger our deepest imaginings of person's life as it is subjectively lived by them.

Yet, the ubiquity of these methods also prompts important questions about the nature of the material they generate. Much depends on what we think is reflected in people's narratives and self-reports given the circumstances under which this material is often elicited. It also depends on the *source* of that material – that is, *from whom* we receive it, relative to the broader universe of patients about whom we're trying to learn. Here again, behavioral science empowers us to recognize the limits of our usual methods and point to ones that might do better at advancing our patientcentric ambitions. One of the science's more interesting lessons concerns the way we actively construct the mental picture not only of our future, but also of our *past and present* when we talk about our thoughts, experiences, and behaviors, often relying on our *theories* about ourselves, as well as our need for *coherence* and *consistency*, to shape that picture.

Along the way, incidental thoughts and feelings can further affect how we recall or anticipate health experiences, such that we may fail to connect with the emotions of a prior distressful moment because we happen to be in calm, steady state, or may underestimate a future treatment burden because a recent flare has made the treatment's potential upsides more salient.<sup>8-9</sup>

These influences can show up in our word choices, what we emphasize, and how we speak. And they can contribute to a mental picture that already leads us to overlook certain experiences, behaviors, or influences simply because they don't align with our expectations or because we lack a way to access them.<sup>10</sup>

### Yet, just as the science sensitizes us to the limits of our traditional methods, it also gives us the ammunition to enrich them with potentially better and more appropriate ones.

We can grab hold of this ammunition by putting ourselves in the behavioral scientist's shoes and asking pointedly, "What is it that we want to learn about patients that might be relevant to the aspects of their *behavior* we'll need to accommodate, support, or help change?"

Using what the science can tell us about this material (e.g., how disease flare memories may impact treatment preferences, and how they are likely recalled) can help us see when verbal narratives and self-reports will likely be useful and when they might mislead us. It can also help us understand the broader role patients' narratives play in their behavior, and when those narratives act merely as entry points (e.g., beliefs we must acknowledge to engage effectively) versus as direct reflections of behavioral drivers and experiences we need to learn about to inform effective action.

Once we do the accounting, we can see where the typical interview methods are likely to fall short. And we can then use the same knowledge to activate methods that fit more closely with the behavioral processes we think will be in play:

- Verbal protocols that allow momentary thoughts, feelings, and intentions to come out through free association during completion of real-world tasks (e.g., deciding on a new treatment)
- Carefully-crafted ideation exercises that use instruction sets, vivid scenarios, and contextual primes to put people in the right real-world experiential state (e.g., seeing a doctor) before responding to interview probes
- **Psychographic surveys** that combine ad-hoc items, psychometrically validated scales, and statistical methods to learn about behavioral dynamics (e.g., drivers of shared decision-making preferences) from correlational patterns
- Formal experiments that elicit behaviors in response to manipulations in real or simulated features of the patient's world, from which hidden behavioral drivers and mental states can then be inferred
- Event sampling methods that blend some of the above using technology such as apps and wearables to deliver stimuli, probe, and capture experiences encountered, and behaviors elicited, in the patient's daily life

Finally, there's the science's lesson about representativeness and the pitfalls of basing conclusions on what we learn from only one or two people. **In life, heterogeneity is the rule, not the exception.** In terms of patients, that means that people with a particular condition can vary dramatically in their needs, experiences, capabilities, and ways of navigating life with the condition. They can also vary dramatically in terms of their communication styles and the way they tell their stories – no small thing when personal narratives and verbal self-reports are the raw material for developing an empathic understanding of the patient.

Behavioral science helps illuminate how this variability might manifest and be driven by factors ranging from personality and culture to demographics and even aspects of the patient's clinical history and profile. That, plus the field's guidance on how to achieve generalizability, nudges us to pay attention to diversity and gives us clues about what to do to make sure we're hearing from a representative sample of patients – **critical to ensuring that patient-centric understandings stay truly patient-centric and don't devolve into an understanding people who are simply "like us".**  greymatter behavioral sciences



#3: A Lens for Clearer Seeing A running theme in this article is that behavioral science's foundational knowledge can tell us something important about our methods, and even say something about *us*, as we try developing a faithful picture of patients.

Worth noting here is the way we supplement raw empathy with entire mental models and everyday reasoning skills to make sense of patients, giving us a filter that guides our thinking and insights methods without us reflecting on it.

This filter is sophisticated, but it is also very imperfect: It introduces blind spots than can cause entire aspects of the patient to stay in the shadows even when the evidence for them is present.

We can neither avoid having a filter nor patch the current one with a few new facts about people and expect the best. But we can strive to have a *whole new filter* – one that's likely to be *better* because it has the sophistication and backing to inch our thinking closer to what's truly behind patients' behaviors and experiences. **It's this "lens" that behavioral science can give us – and it can be one of our best tools for putting us on the path to seeing patients more clearly in all their complexity.** 

# Why do we believe that the lens we acquire from behavioral science would be "better"?

### Consider a type of experience many life sciences companies have had:

A brand team, operating under a specific business objective (e.g., maximize clinical trial retention rates), speaks with patients to learn about their experiences with a given condition, along with their needs and desires regarding treatment, condition-related coping, health selfmanagement, and healthcare participation. Based on the team's interpretation of what they hear, strategies and solutions ideas are generated, which may be presented to patients in the form of concepts, prototypes, or other artifacts to gauge their reaction and further refine the team's understanding of the patient perspective. At some point, the signal from patients suggests that the team's thinking is on the right track. Then, the team executes against what they've learned, and what's observed in market falls short of expectations.

Moments like these can be frustrating due to their costs and risks, and they can leave teams rudderless in knowing how to respond. Viewed through an everyday lens, the patients' behavior can seem like excessive resistance or an inexplicable (and potentially irrational) deviation from what their own feedback would suggest. greymatter behavioral sciences

# But through a behavioral science lens, the same actions can easily appear quite different.

What looks like resistance or irrationality can, based on other evidence from the science, come to be seen as something potentially important about how patients *naturally attend to* and *cope with* conditionrelated burdens and threats – responses that may be quite adaptive *even if* they stand in the way of behaviors like starting a new treatment that patients value in other respects.<sup>11</sup>

The dynamics at play in these behaviors may be subtle: Patients may not recognize them because they're not activated in the moment they're queried about them or because they lack the language to describe them. We, too, may miss the signals for them in patients' narratives and behaviors simply because we don't have the proper lens to connect the dots. But with the right lens, we may start to see the evidence for these dynamics more clearly – and once we do, we can be better equipped to describe, confirm, and, if validated, act on them in ways that will support and engage patients more effectively. What a lens from behavioral science can do, then, is help us make sense of complex patterns in patients' ways of thinking and behaving that can confound us, opening us to aspects of the patient that would otherwise stay invisible thanks to everyday ways of reasoning that fail to do patients justice.

We then bring the science's benefits home when we use its methods to test what we see, allowing us to confirm what we're seeing truly fits the patient's reality, and giving us a process we can pull into problem-solving to ensure solutions stay aligned with what patients want and need. **To the extent that the result is a well-rounded picture of patients that's consistent with their reality, what** we get can be as empathically patient-centric as anything we'd look to obtain from our everyday ways of trying to see patients on their terms.

# Conclusions and Key Steps

The forces that have prompted the life sciences industry to embrace patient centricity are only likely to accelerate, and this article has focused on behavioral science as a tool the industry should leverage in its quest to develop optimal patient-centric insights, tactics, and strategies. In saying this, it's important to note that not just any way of using behavioral science will produce these results. Cookbook approaches that are fragmented and simplistic are unlikely to unlock the science's value however digestible they may be. But we *can* unlock the value when we approach behavioral science as a *rich, holistic discipline* – one that carefully maps patients' behavioral needs to patient-centered objectives, then activates a broad swath of scientific knowledge and methods to:

- Generate a well-rounded, well-synthesized, evidence-based picture of the patient;
- Drive ideas about strategies and solutions that work by meeting patients where they are based on evidence; and
- Mitigate the biases that can creep into our own inferences about patients.

Life sciences companies can capitalize on this way of utilizing behavioral science to develop empathic, multi-layered portraits of patients and find ways to effectively help patients access and use the industry's innovations – but to reap the benefits, there are some steps life sciences professionals need to take. And among the best steps are those that involve:

- Treating behavioral science as part of the foundation for every element of their patientcentric efforts – in effect making this a mantra for all patient-focused work;
- Learning more from industry behavioral scientists about the approach to the science that's advocated for here – not to master it, but to have enough facility to understand what it entails, how it works, and what it looks like when it's provided; and
- Leveraging those same experts to help industry professionals apply this approach across their patient-focused initiatives from insight and strategy to concrete solutions development.





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### **About Greymatter**

**Greymatter Behavioral Sciences** is a consultancy that specializes in delivering hands-on, expert-led behavioral science applications for insight, strategy, and the design of communications, services, and experiences that accommodate, change, and support people's behavior for positive, person-centric ends. For more, visit **greymatterbehavioralsciences.com**.



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