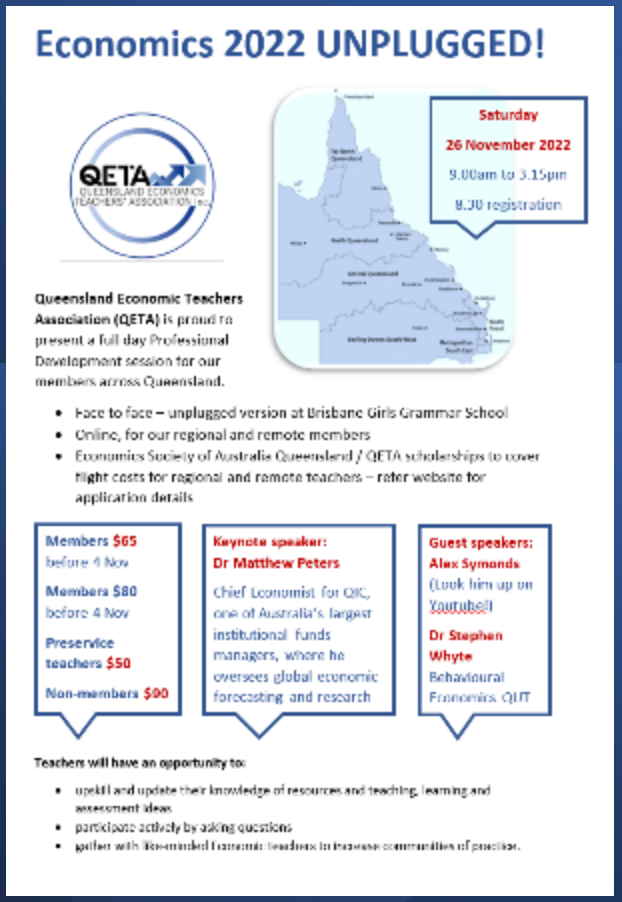
Welcome



Economics 2022 UNPLUGGED!

QETA
QUEENSLAND ECONOMICS TEACHERS' ASSOCIATION Inc.

Saturday
26 November 2022
9.00am to 3.15pm
8.30 registration

Queensland Economic Teachers Association (QETA) is proud to present a full day Professional Development session for our members across Queensland.

- Face to face – unplugged version at Brisbane Girls Grammar School
- Online, for our regional and remote members
- Economics Society of Australia Queensland / QETA scholarships to cover flight costs for regional and remote teachers – refer website for application details

Members $65
before 4 Nov

Members $80
before 4 Nov

Preservice teachers $50

Non-members $90

Keynote speaker:
Dr Matthew Peters
Chief Economist for QIC, one of Australia's largest institutional funds managers, where he oversees global economic forecasting and research

Guest speakers:
Alex Symonds
(Look him up on Youtube!)

Dr Stephen Whyte
Behavioural Economics QUT

Teachers will have an opportunity to:

- upskill and update their knowledge of resources and teaching, learning and assessment ideas
- participate actively by asking questions
- gather with like-minded Economic leaders to increase communities of practice.

QETA
QUEENSLAND ECONOMICS TEACHERS' ASSOCIATION Inc.

Guest speaker:

Dr Stephen Whyte

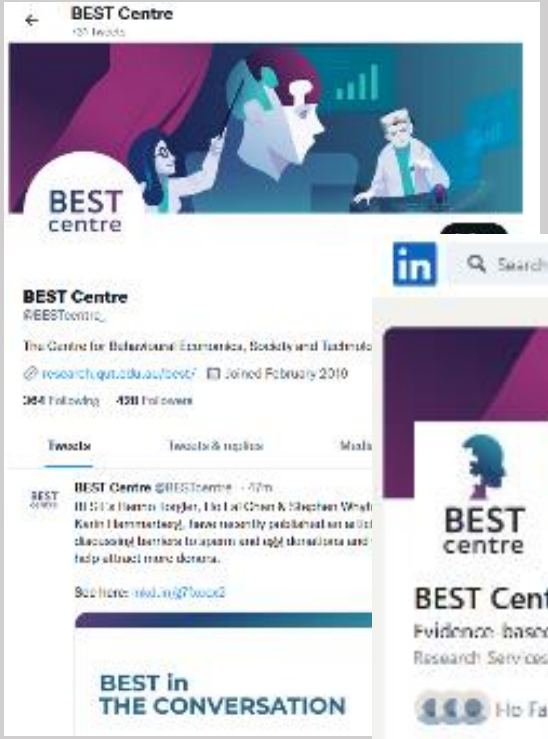
Behavioural Economics

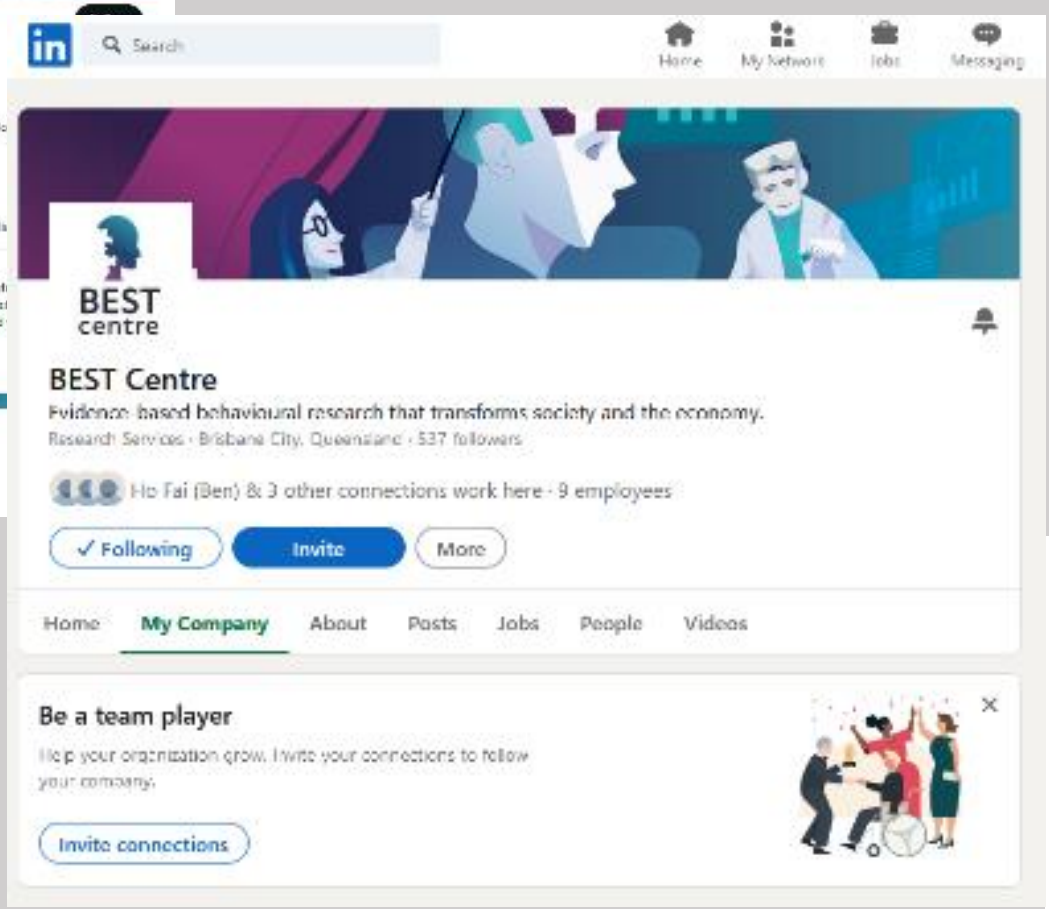
Using Behavioural Economics in the Real World

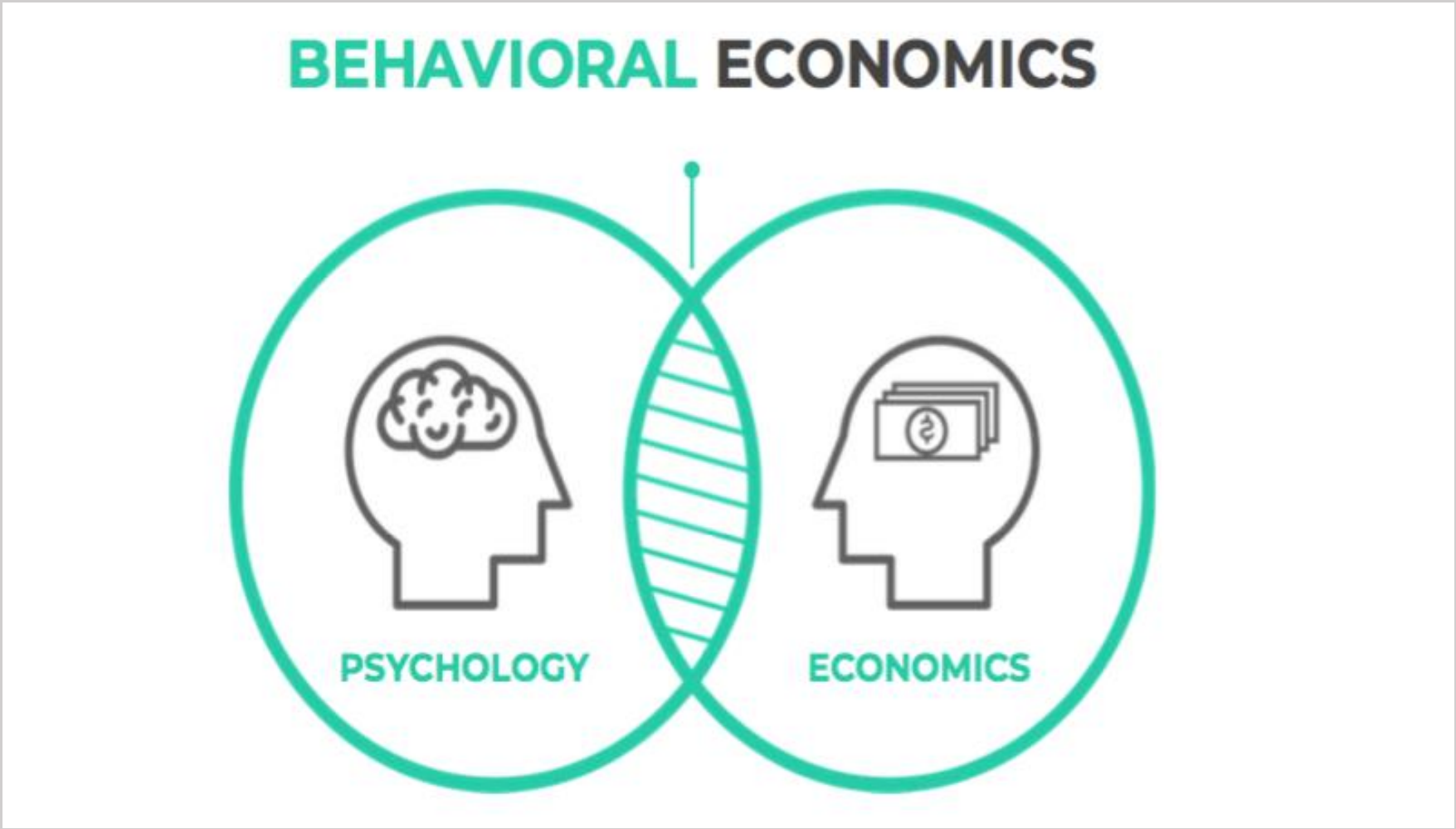
Dr Stephen Whyte

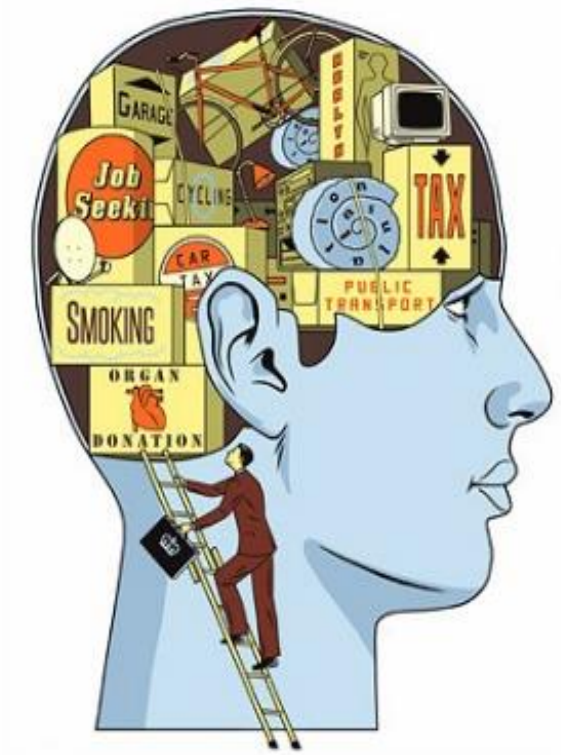
Research Fellow, School of Economics & Finance, Faculty of Business and Law, Queensland University of Technology

Co-Deputy Director – Centre for Behavioural Economics, Society and Technology (BEST)



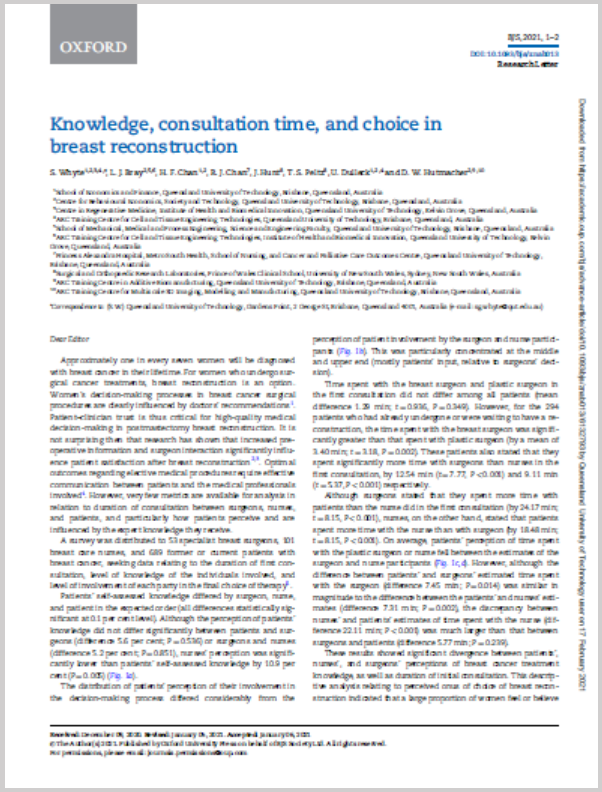






Relevant fields:

- The Economy
- Government
- Business
- Health -Medicine
- Law
- STEM
- the Arts
- Sport
- etc, etc, etc….



OXFORD

BJS, 2021, 1–2
DOI: 10.1093/bjs/znab011
Research Letter

Knowledge, consultation time, and choice in breast reconstruction

S. Whyte[1,2,3,4], L. J. Bray[2,5,6], H. F. Chan[1,2], B. J. Chan[7], J. Hunt[8], T. S. Peled[9], D. Dellal[1,2,4] and D. W. Hutmacher[2,9,10]

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Dear Editor

Approximately one in every seven women will be diagnosed with breast cancer in their lifetime. For women who undergo surgical cancer treatments, breast reconstruction is an option. Women's decision-making processes in breast cancer surgical procedures are heavily influenced by doctors' recommendations[1]. Patient–clinician trust is thus critical for high-quality medical decision-making in postmastectomy breast reconstruction. It is not surprising then that research has shown that increased preoperative information and surgeon interaction significantly influence patient satisfaction after breast reconstruction[2,3]. Optimal outcomes regarding elective medical procedures require effective communication between patients and the medical professionals involved[4]. However, very few metrics are available for analysis in relation to duration of consultation between surgeons, nurses, and patients, and particularly how patients perceive and are influenced by the expert knowledge they receive.

A survey was distributed to 53 specialist breast surgeons, 101 breast care nurses, and 689 former or current patients with breast cancer, seeking data relating to the duration of first consultation, level of knowledge of the individuals involved, and level of involvement of each party in the final choice of therapy[5].

Patients' self-assessed knowledge differed by surgeon, nurse, and patient in the expected order (all differences statistically significant at 0.1 per cent level). Although the perception of patients' knowledge did not differ significantly between patients and surgeons (difference 5.6 per cent; $P_{adj} = 0.536$) or surgeons and nurses (difference 5.2 per cent; $P_{adj} = 0.651$), nurses' perception was significantly lower than patients' self-assessed knowledge by 10.9 per cent ($P_{adj} = 0.005$) (Fig. 1a).

The distribution of patients' perception of their involvement in the decision-making process differed considerably from the perception of patient involvement by the surgeon and nurse participants (Fig. 1b). This was particularly concentrated at the middle and upper end (mostly patients' input, relative to surgeons' decision).

Time spent with the breast surgeon and plastic surgeon in the first consultation did not differ among all patients (mean difference 1.26 min; $t_{adj} = 0.936$, $P_{adj} = 0.349$). However, for the 294 patients who had already undergone or were waiting to have a reconstruction, the time spent with the breast surgeon was significantly greater than that spent with plastic surgeon (by a mean of 3.40 min; $t_{adj} = 3.18$, $P_{adj} = 0.002$). These patients also stated that they spent significantly more time with surgeons than nurses in the first consultation, by 12.54 min ($t_{adj} = 7.77$, $P < 0.001$) and 9.11 min ($t_{adj} = 5.97$, $P < 0.001$) respectively.

Although surgeons stated that they spent more time with patients than the nurse did in the first consultation (by 24.17 min; $t_{adj} = 8.15$, $P < 0.001$), nurses, on the other hand, stated that patients spent more time with the nurse than with surgeon (by 18.48 min; $t_{adj} = 8.15$, $P < 0.001$). On average, patients' perception of time spent with the plastic surgeon or nurse fell between the estimates of the surgeon and nurse participants (Fig. 1c,d). However, although the difference between patients' and surgeons' estimated time spent with the surgeon (difference 7.45 min; $P_{adj} = 0.014$) was similar in magnitude to the difference between the patients' and nurses' estimates (difference 7.31 min; $P_{adj} = 0.002$), the discrepancy between nurses' and patients' estimates of time spent with the nurse (difference 22.11 min; $P < 0.001$) was much larger than that between surgeons and patients (difference 5.77 min; $P_{adj} = 0.239$).

These results showed significant divergence between patients', nurses', and surgeons' perceptions of breast cancer treatment knowledge, as well as duration of initial consultation. This descriptive analysis relating to perceived onus of choice of breast reconstruction indicated that a large proportion of women feel or believe

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LETTER

Exploring sexual orientation beyond genital arousal: Using large-scale online dating contact behavior to study male and female bisexuality

Ho Fai Chan[a,b], Benno Torgler[a,b], and Stephen Whyte[a,b,c,1]

Jabbour et al. (1) examine the extent to which men who self-report bisexual orientation exhibit bisexual genital arousal, employing a larger sample than had been used in previous research ($n = 588$ who provided self-reported arousal data; $n = 474$ with genital responses). The results confirm that men who report attraction to both sexes are also more genitally aroused by both sexes; therefore, they speculate that sample size and systematic differences between samples of bisexual men (including misclassification) may have contributed to inconsistent results in previous studies. What the research in this field has so far failed to explore is how important insights can be generated beyond measurements of genital arousal or subjective orientation; for example, by exploring real-world online dating contact behavior as a way of measuring revealed preferences. Such data also offer the advantage of substantially larger sample sizes than historical laboratory studies.

Our dataset comprises online dating contact behavior from 946 bisexual men and 623 bisexual women (2), allowing us to go beyond just looking at male bisexuality. Jabbour et al. (1) in fact stress how "converging lines of evidence suggest that there are important differences in the expression of male and female sexual orientation, perhaps especially bisexuality" (p. 18370). However, by simply exploring the distribution of bisexual online dating participants who prefer to contact exclusively 1) same sex only, 2) opposite sex only, and 3) both sexes, we find no statistically significant difference between bisexual men and women ($n = 1,569$; χ^2 test: $P = 0.166$). In fact, we find relatively more bisexual men (74.52%) contacting both sexes compared with bisexual women (70.63%), and fewer bisexual men (12.47%) contacting men only compared with bisexual women contacting women only (15.57%). When exploring the contact behavior of bisexual men and women according to their Kinsey scale (KS) (Fig. 1), none of the respondents scoring between 0 and 5 exhibits a difference in the distribution of contact preferences between bisexual men or women (χ^2 tests, $P > 0.1$). The overall pattern of change in the relative share of contact types across the KS does appear symmetrical for both sexes. However, the rate of such differences cross the spectrum is not (e.g., for KS = 1, 23.5% of bisexual males who contact women only are not represented in KS = 5 by the 54.1% bisexual males who contact men only).

While misclassification undoubtedly exists in the bisexual male population, the fact that online dating contact behavior shows no statistically significant sex difference suggests that it likely also exists in the bisexual female population, and that previous sex difference findings relating to genital blood flow assessments and their association with sexual orientation may be problematic (3, 4). That Jabbour et al. (1) excluded 26.73% of bisexual males for "insufficient genital arousal for meaningful analysis" (p. 18375) speaks to such issues. This therefore suggests the importance of mixed methods to understand bisexual orientation and alternative proxies for arousal and revealed preferences. As Zivony (5) argues, the complexity of sexual orientation cannot be reduced to genital arousal. However, contrary to Zivony (5), we encourage sexual orientation scientists to look beyond subjective measures and utilize the plethora of new field data available.

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Author contributions: H.F.C., B.T., and S.W. designed research, performed research, analyzed data, and wrote the paper.
The authors declare no competing interest.

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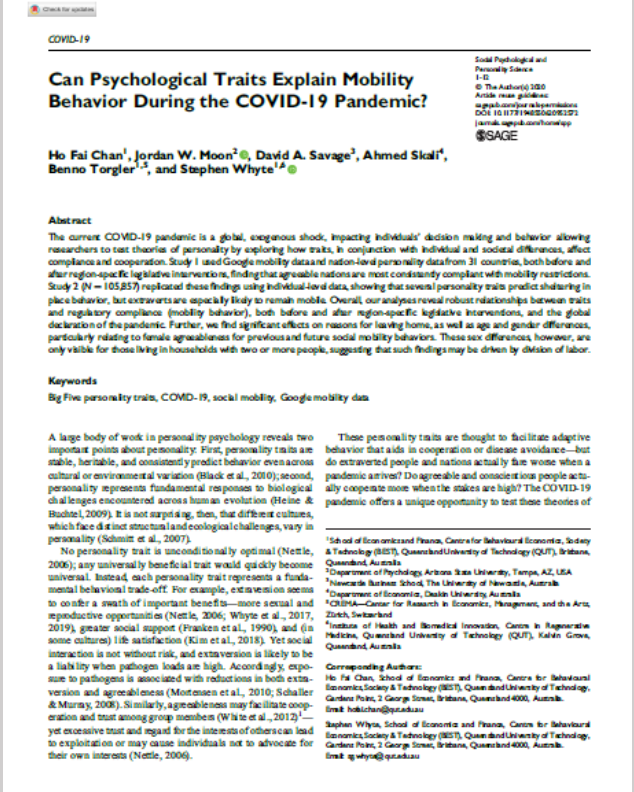

COVID-19

Can Psychological Traits Explain Mobility Behavior During the COVID-19 Pandemic?

Social Psychological and Personality Science
1–12
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SAGE

Ho Fai Chan[1], Jordan W. Moon[2], David A. Savage[3], Ahmed Skali[4], Benno Torgler[1,5], and Stephen Whyte[1,6]

Abstract

The current COVID-19 pandemic is a global, exogenous shock, impacting individuals' decision making and behavior allowing researchers to test theories of personality by exploring how traits, in conjunction with individual and societal differences, affect compliance and cooperation. Study 1 used Google mobility data and nation-level personality data from 31 countries, both before and after region-specific legislative interventions, finding that agreeable nations are most consistently compliant with mobility restrictions. Study 2 ($N = 105,857$) replicated these findings using individual-level data, showing that several personality traits predict sheltering in place behavior, but extraverts are especially likely to remain mobile. Overall, our analyses reveal robust relationships between traits and regulatory compliance (mobility behavior), both before and after region-specific legislative interventions, and the global declaration of the pandemic. Further, we find significant effects on reasons for leaving home, as well as age and gender differences, particularly relating to female agreeableness for previous and future social mobility behaviors. These sex differences, however, are only visible for those living in households with two or more people, suggesting that such findings may be driven by division of labor.

Keywords

Big Five personality traits, COVID-19, social mobility, Google mobility data

A large body of work in personality psychology reveals two important points about personality: First, personality traits are stable, heritable, and consistently predict behavior even across cultural or environmental variation (Black et al., 2010); second, personality represents fundamental responses to biological challenges encountered across human evolution (Heine & Buchtel, 2009). It is not surprising, then, that different cultures, which face distinct structural and ecological challenges, vary in personality (Schmitt et al., 2007).

No personality trait is unconditionally optimal (Nettle, 2006); any universally beneficial trait would quickly become universal. Instead, each personality trait represents a fundamental behavioral trade-off. For example, extraversion seems to confer a swath of important benefits—more sexual and reproductive opportunities (Nettle, 2006; Whyte et al., 2017, 2019), greater social support (Franken et al., 1990), and (in some cultures) life satisfaction (Kim et al., 2018). Yet social interaction is not without risk, and extraversion is likely to be a liability when pathogen loads are high. Accordingly, exposure to pathogens is associated with reductions in both extraversion and agreeableness (Mortensen et al., 2010; Schaller & Murray, 2008). Similarly, agreeableness may facilitate cooperation and trust among group members (White et al., 2012)[1]—yet excessive trust and regard for the interests of others can lead to exploitation or may cause individuals not to advocate for their own interests (Nettle, 2006).

These personality traits are thought to facilitate adaptive behavior that aids in cooperation or disease avoidance—but do extraverted people and nations actually fare worse when a pandemic arrives? Do agreeable and conscientious people actually cooperate more when the stakes are high? The COVID-19 pandemic offers a unique opportunity to test these theories of

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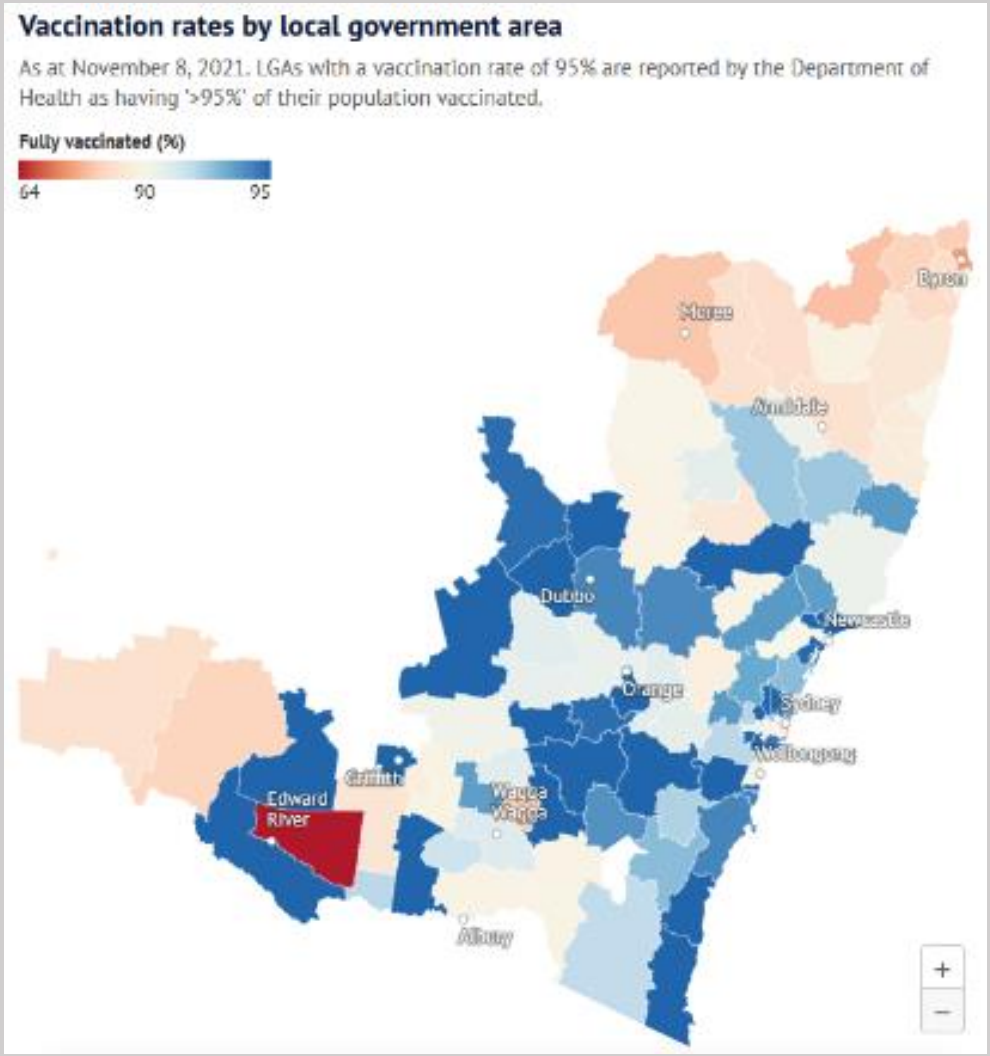
What is a credence good?

a type of good with qualities that cannot be observed by the consumer after purchase, making it difficult to assess its utility

Cognitive and Behavioural Bias in Decision Making

Brisbane floods 2011 & 2022
- Neglect of probability
(Probability bias)

Anti Vax movement & Vaccine Hesitancy 2021
- Confirmation bias



Health Minister Greg Hunt said the $24 million advertising campaign would be rolled out across TV, radio, print, social and digital media.

'The information in this campaign, based on expert and independent medical advice, will help answer the questions people may have.'

BEST Centre - Applied Behavioural Program of Research: Technology Adoption in (Medical/Health) Credence Markets

Breast Cancer Surgery

Whyte, S., Bray, L.J., Chan H.F., Chan, R.J., Hunt, J., Peltz, T.S., Dulleck, U., & Hutmacher, D.W. (2021) Cognitive bias and therapy choice in breast reconstruction surgery decision making. *Plastic & Reconstructive Surgery. 149*(4), 629e-637e

Whyte, S., Bray, L. J., Chan, H. F., Chan, R. J., Hunt, J., Peltz, T. S., Dulleck, U., & Hutmacher, D.W. (2021). Knowledge, consultation time, and choice in breast reconstruction. *British Journal of Surgery*, *108*(4), e168-e169.

Whyte, S., Bray, L.J., Chan H.F., Chan, R.J., Hunt, J., Peltz, T.S., Dulleck, U., & Hutmacher, D.W. (2022) Exploring Surgeons', nurses' and patients' information seeking behaviour on medical innovations: The case of 3D printed biodegradable implants in breast reconstruction. *Annals of Surgery Open.* in press

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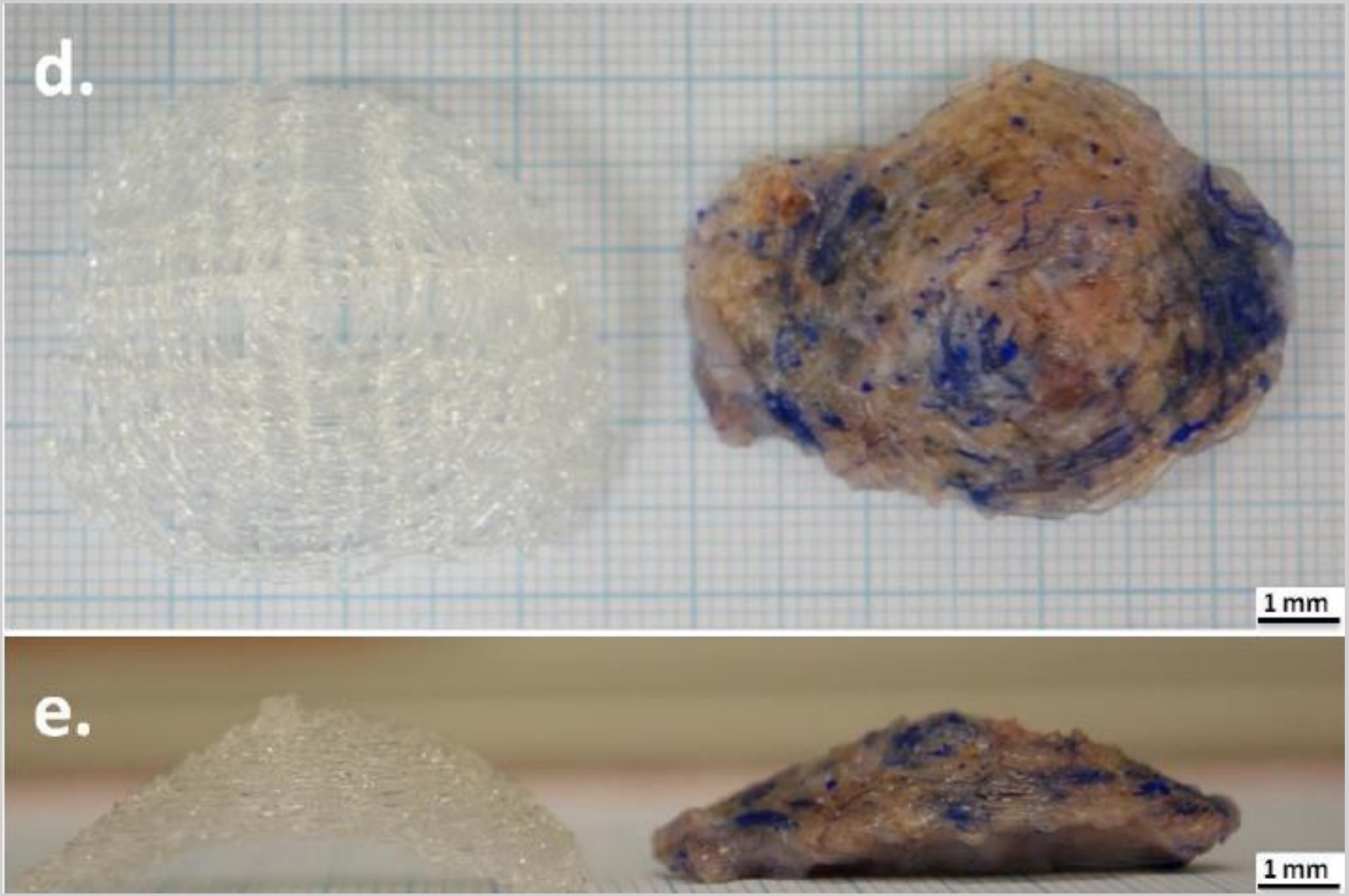


Sample – Patients, Nurses and Surgeons

- We collected data from (*N*=761) breast cancer patients, identifying their demographics, breast cancer & reconstruction history and behavioural biases.
- A matching survey of plastic surgeons and breast & endocrine surgeons (*N*=53), and breast care nurses (*N*=101) has also been collected to identify behaviour and whether the biases of patients, nurses and surgeons reinforce or counteract each other.

Question:

Jonathan is an ex-professional football player for Queensland. After he finished playing professionally, Jonathan became a physical education teacher at a local high school. Jonathan has two sons, both of whom are excellent athletes.

Which is more likely?

0.50 = 50% a) Jonathan coaches a local junior football team

b) Jonathan coaches a local junior football team, and plays a little seniors football with the local pub team

0.50 x 0.50 = 25%

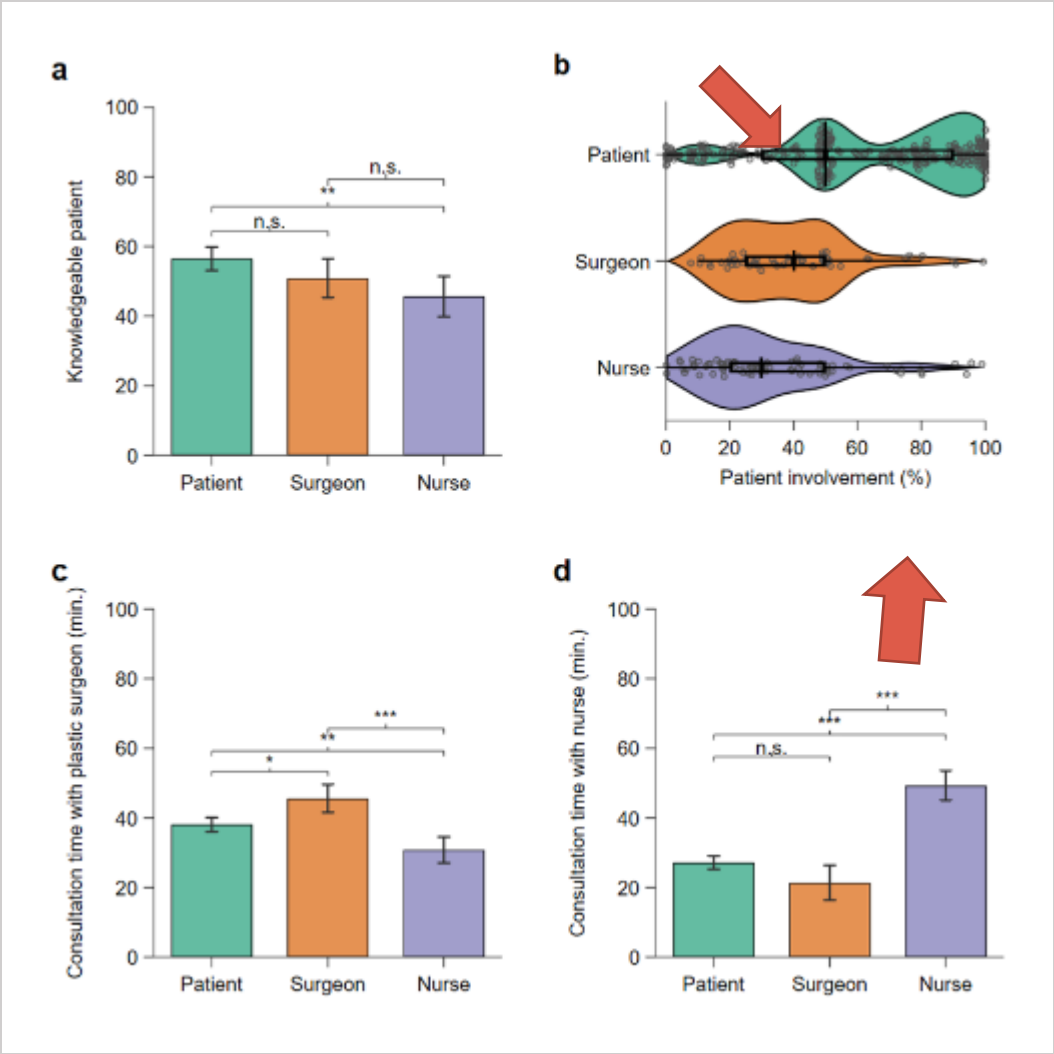
N=574 Breast Cancer patients
74.22% exhibit "conjunction fallacy"

Table 2: Estimate of time spent with patient in the 1st consultation by *Patient*, *Nurse*, and *Surgeon*.

Participant	Target	*N*	Mean (min.)	*SD*
Patient	with B&E[7] surgeon	597	39.38	20.12
	with Plastic surgeon	302	38.09	18.14
	with Nurse	592	27.15	23.75
Surgeon	with Surgeon	53	45.55	14.53
	with Nurse	53	21.38	18.23
Nurses	with Surgeon	84	30.79	17.26
	with Nurse	84	49.26	19.54

Note: The Pearson correlation between time spent with B&E surgeon and Plastic surgeon in 1st consult is high (0.564, $P < 0.0001$, n=294 patients who are either waiting to have or have already had a reconstruction).

Whyte, S., Bray, L. J., Chan, H. F., Chan, R. J., Hunt, J., Peltz, T. S., ... & Hutmacher, D. W. (2021). Knowledge, consultation time, and choice in breast reconstruction. *British Journal of Surgery*, *108*(4), e168-e169.



Note: For **a**, **c**, and **d**, *t*-test (two-tailed) was used to compare mean level between the three groups. Error bar represents 95% confidence interval. P-values are adjusted for multiple comparison using the Bonferroni correction). †P < 0.1; *P < 0.05; **P < 0.01; ***P < 0.001; n.s. not significant. For **b**, dots represent individual data points and the "violins" the relative kernel density across the entire range of values. Boxes represent median ± IQR, whiskers represent 1.5*IQR.

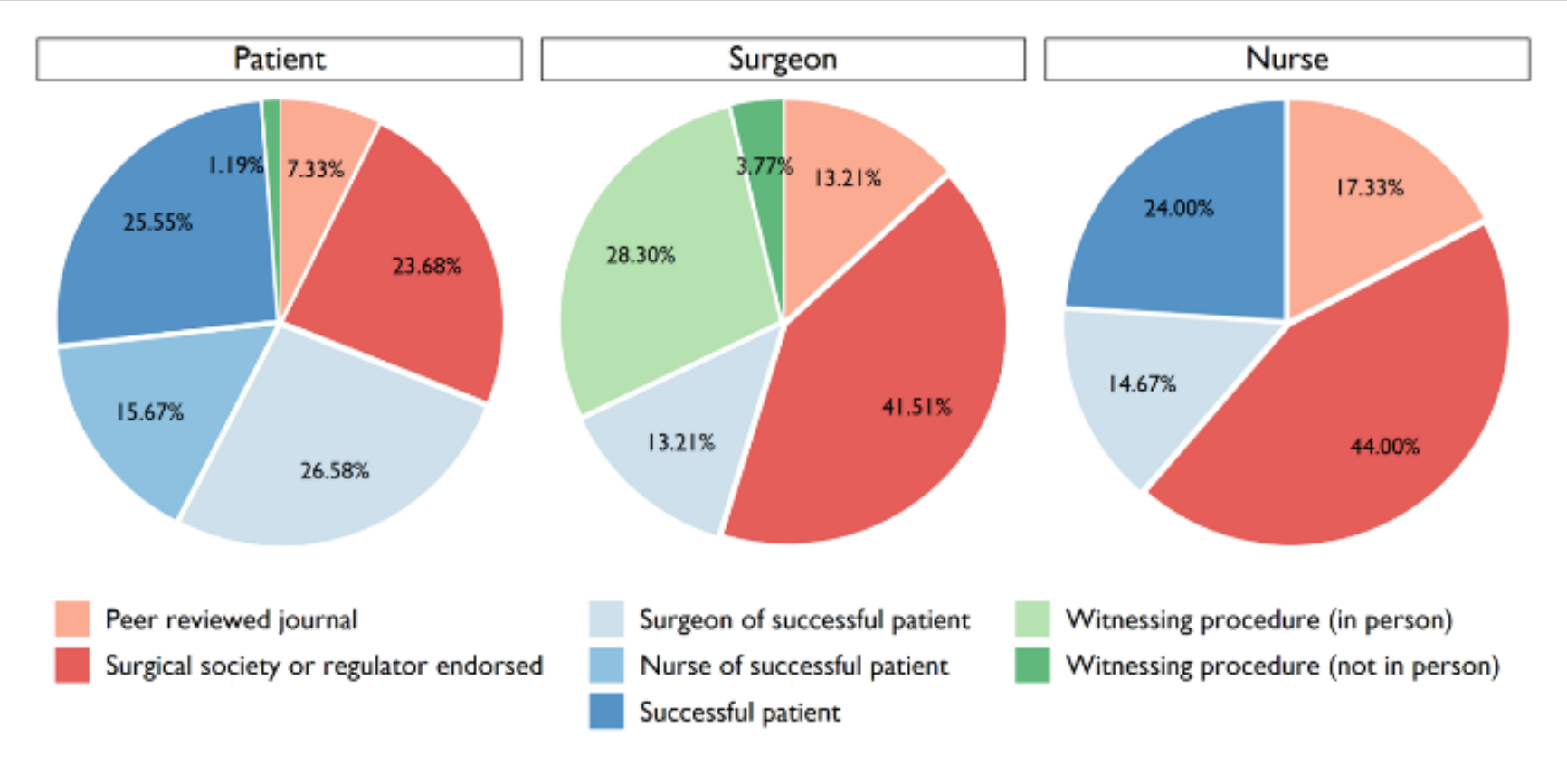
Fig. 1. Perceived level of patient's knowledge in breast cancer reconstruction procedure (**a**), involvement in breast reconstruction decision-making process (**b**), and consultation time with plastic surgeon (c) and nurse (**d**), by patients, surgeons, and nurses.

Table 5: Factors impacting patient choice of reconstruction type

Dep. Var.	Had a reconstruction		Sole implant-based approach		Implant & tissue-based approach	
Indep. Var.	*OLS*	*Probit*	*OLS*	*Probit*	*OLS*	*Probit*
	(1)	(2)	(3)	(4)	(5)	(6)
Age	-.0143***	-.0426***	-.0087*	-.023*	-.0103**	-.0287**
	(.0023)	(.0081)	(.0039)	(.0102)	(.0035)	(.0101)
Weight	-.0029	-.0088†	-.0029	-.0076	-.0034	-.0094
	(.0018)	(.0051)	(.0025)	(.0066)	(.0025)	(.0066)
		-.0029		*-.0028*		*-.0034*
Height	.0037	.0104	.0029	.0076	.0034	.0093
	(.0039)	(.0119)	(.0052)	(.0136)	(.005)	(.0136)
		.0035		*.0028*		*.0033*
Ethnic=Caucasian	-.1453	-.5196	-.2037	-.578	-.0952	-.2682
	(.1301)	(.5793)	(.2172)	(.6767)	(.2216)	(.6855)
		-.1548		*-.2098*		*-.0928*
Residency=Australia	.0102	.0324	-.0024	-.0098	.0348	.1025
	(.1092)	(.3319)	(.1426)	(.3726)	(.1394)	(.375)
		.0109		*-.0036*		*.0372*
Marital status=Single	.0815	.2139	.0767	.2128	.0677	.1929
	(.0914)	(.2706)	(.1281)	(.3337)	(.1196)	(.3209)
		.069		*.0789*		*.0678*
Offspring=Yes	.1152	.3178	.1012	.2604	.055	.1434
	(.0719)	(.2123)	(.1019)	(.2676)	(.0943)	(.2545)
		.1088		*.0959*		*.052*
Family history of breast cancer=Yes	-.013	-.0109	-.0458	-.1224	-.0108	-.0351
	(.0506)	(.1485)	(.0719)	(.1865)	(.0706)	(.1888)
		-.0037		*-.0454*		*-.0126*
Public (State) School	.1049†	.2996†	-.0209	-.0568	.0488	.1295
	(.055)	(.1599)	(.0759)	(.1964)	(.0755)	(.2018)
		.1022		*-.0211*		*.0468*
Person Income	4.9e-07	1.3e-06	-3.7e-07	-1.0e-06	-2.2e-07	-5.7e-07
	(5.1e-07)	(1.6e-06)	(7.0e-07)	(1.8e-06)	(6.9e-07)	(1.9e-06)
		4.2e-07		*-3.9e-07*		*-2.1e-07*
Private Insurance=Yes	.0905†	.2622†	.1078	.2965	.127†	.3403†
	(.054)	(.1578)	(.0731)	(.1959)	(.0728)	(.1975)
		.0884		*.1094*		*.1239*
log(Time since reconstruction)			.0714	.198	.0344	.0999
			(.0788)	(.2024)	(.0784)	(.207)
				.0735		*.0359*
log(Duration between mastectomy and reconstruction)			-.1094*	-.2965*	-.1029*	-.2725*
			(.0507)	(.1327)	(.051)	(.1342)
				-.11		*-.098*
Constant	.9418	1.549	.7533	.6902	.7905	.8208
	(.6689)	(2.109)	(.9041)	(2.412)	(.8649)	(2.407)
N	350	350	222	222	222	222
Prob > *F* (χ^2)	2.11e-07	.0000348	.0509	.134	.0734	.151
(Pseudo) R^2	0.118	0.096	0.082	0.062	0.086	0.065

Notes: Standard errors (robust) in parentheses. Marginal effects in italics. † $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Adopting biomaterials in breast reconstruction: Exploring surgeon, nurse, and patient preference



Advanced Care Planning

Advance care planning is **the process of planning for your current and future health care**.

It involves talking about your values, beliefs and preferences with your loved ones and doctors.

This helps them make decisions about your care when you can't.

Advanced Care Planning

In 2021 we collected data from the Australian general public *n*= 1253, General practitioners (GPs) and nurses (*n* = 117) including demographics, stated preference for ACP decision-making; six cognitive bias tests commonly used in Behavioural Economics; and a framing experiment in the context of ACP.

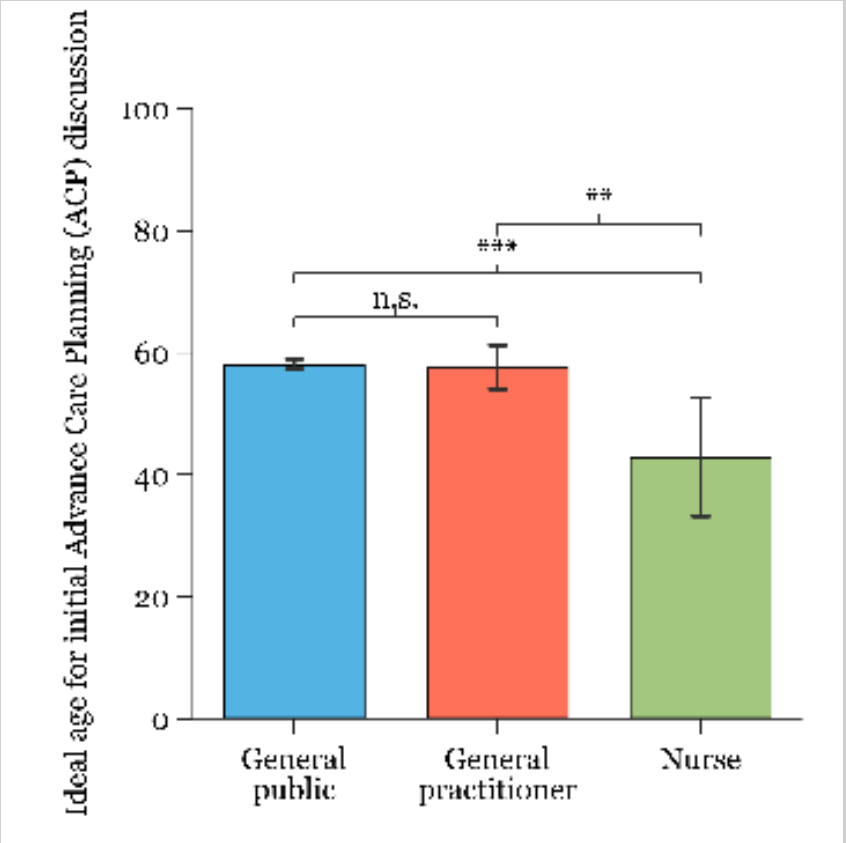


Fig 1. Share of doctor–patient contribution in ACP/EOL decision making, by group.

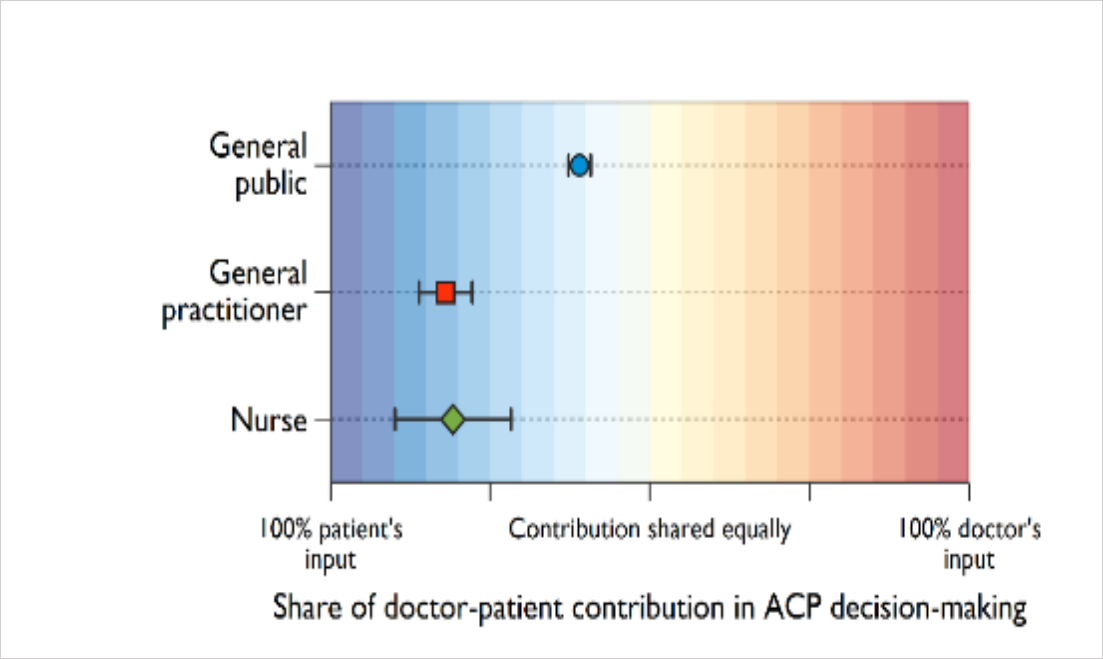


Fig 2. Ideal age of first ACP/EOL discussion by group

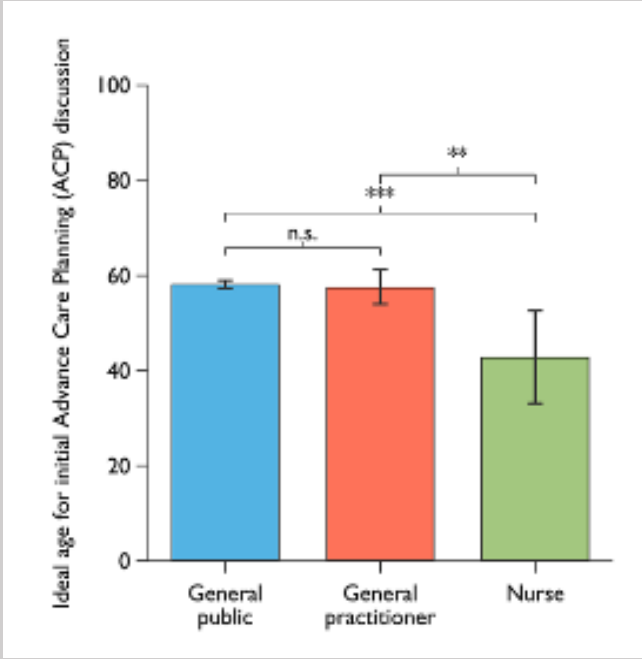


Table 5. ACP experience and bias interaction for age of first ACP discussion – General Pop.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Experience with ACP	0.9349 (1.177)	−0.6379 (1.383)	−0.6127 (1.334)	−1.735 (1.281)	−0.9236 (1.182)	1.328 (1.37)	−4.108 (2.504)
ACP experience × Conjunction fallacy	−0.7117 (1.64)						−0.4084 (1.659)
ACP experience × Illusion of control bias		1.878 (1.722)					1.37 (1.714)
ACP experience × Endowment effect			1.984 (1.69)				1.639 (1.712)
ACP experience × Herd bias				4.373** (1.634)			4.279** (1.653)
ACP experience × Confirmation bias							
ACP experience × Loss aversion						−1.157 (1.69)	−0.9696 (1.685)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes
N	1138	1138	1138	1138	1138	1138	1138
R^2	0.191	0.192	0.192	0.196	0.194	0.191	0.201
Adjusted R^2	0.164	0.165	0.165	0.169	0.166	0.164	0.170
AIC	9141.7	9140.7	9140.4	9134.3	9138.4	9141.4	9138.5
BIC	9333.1	9332.1	9331.8	9325.7	9329.8	9332.9	9355.1

ACP, advance care planning; AIC, Akaike information criterion; BIC, Bayesian information criterion.
Dependent variable: Ideal age for initial ACP discussion. Standard errors (robust) in parentheses.
$^{\dagger}p<0.10$; $^{*}p<0.05$; $^{**}p<0.01$; $^{***}p<0.001$.

Health Minister Greg Hunt said the $24 million advertising campaign would be rolled out across TV, radio, print, social and digital media.

"The information in this campaign, based on expert and independent medical advice, will help answer the questions people may have."

Behavioural Economics and Technology Adoption in Credence Markets – *Into the future?*

Bachelor of Business (Behavioural Economics) at QUT

Bachelor of Business (Behavioural Economics)

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Major units:

- Multi-disciplinary approaches to behaviour changes
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- Introduction to applied econometrics
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Human Resources	Entrepreneurship and Innovation *

*New majors for 2023

Bachelor of Business (Behavioural Economics) overview

Complementary Study:

Option 1:
8 Units: Second major

Option 2:
4 Units: Minor +
4 Units: Second minor or elective units

Option 3:
8 Units: Elective units

Double degrees combine the core and majors of two disciplines to save time and build enduring skills

Complete 2 degrees
In 4 years

(Some double degrees take longer)

Advantages of studying a business double degree

Career outcomes

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- government
- business
- health and medicine
- law
- STEM
- the arts
- sport.

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Behavioural Economics course page

BEST Conference 2023

BEST Conference 2023

5th Annual BEST Conference on Human Behaviour & Decision Making 2023

In 2023, the BEST Centre will host the 5th annual "BEST Conference on Human Behaviour and Decision Making" on **Thursday 2nd & Friday 3rd February** at the Queensland University of Technology, Gardens Point Campus, Brisbane Australia.

About

The Centre for Behavioural Economics, Society and Technology (BEST) is a national and international leader in applied behavioural research. The Centre draws on QUT's expertise in applied economics and social marketing, while leveraging and amplifying QUT's expertise in health, science, technology and creative industries. The BEST Centre brings together researchers interested in applying Behavioural Insights to address real world problems in close collaboration with government, industry and the not-for-profit sector.

The conference will bring together academic, private sector and policy researchers to share, learn and collaborate on scientific research focused on understanding human behaviour, and how that impacts decision making and thus society more broadly.

The Conference welcomes researchers from all fields, including but not limited to: Applied & Experimental Economics, Social Marketing, Psychology, Sociology, Social Psychology & Evolutionary Psychology, Evolutionary Biology, Education, Health, Demography, Sexuality & Gender, Political Science, Religion, Anthropology, Scientometrics, Sports, Engineering, Mathematics, Management, Business Studies, Creative Industries, and Philosophy.

BEST Conference 2023

- 2023 Plenary Speakers

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- BEST Conference 2022 Session Presentations
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- 2021 Plenary Speakers
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