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Health and the Information Nonseeker: A Profile

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Health and the Information Nonseeker: A Profile

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Despite increased information-seeking by the public, a significant percentage of those diagnosed with a serious disease such as cancer report that they do not seek or receive health information beyond that given by health care providers. This study attempts to profile these nonseekers and study possible determinants of nonseeking behaviors. Data come from the 2003 Health Information National Trends Survey, a national survey of American adults conducted by the National Cancer Institute ($N = 6,133$; Nelson et al., 2004). Individuals were categorized as nonseekers or seekers and then further classified based on cancer history to yield four groups: nonseeker patients, the nonseeker public, seeker patients, and the seeker public. Compared to other groups, nonseeker patients came from the lowest income and education groups, and scored lower on attention to health in the media and trust in mass media health information. Nonseekers also scored lower on preventative health behaviors.

Information seeking is a critical concept in health communication in light of the growing trend among patients, advocates, and scholars to move away from the paternalistic model of patient–provider communication toward more informed or shared decision making (Johnson, 1997; Rimer, Briss, Zeller, Chan, & Woolf, 2004). The conventional assumption is that when they have to make a health-related decision, patients actively look for health information, weigh the pros and cons of options, use their values and preferences, and then actively engage in decision making with their providers (Balint & Shelton, 1996; Charles, Whelan, Gafni, Willan, & Farrell, 2003; Rimer et al., 2004). This is in line with the classical American value placed on an informed citizenry, in this case describing patients who make rational choices about health and medical options leading to satisfaction with the process and health outcomes. Whether or not informed or shared decision making leads to better health outcomes is an empirical question, but more critical is the assumption that information seeking is an important element

in decision making and in health outcomes (Johnson, 1997; Rimer et al., 2004).

Despite recent reports about increased interest in health information in the general public, and the assumption that information seeking is important, not all individuals diagnosed with a serious condition actively seek information from sources other than their health care providers (Czaja, Manfredi, & Price, 2003; Leydon et al., 2000; Rees & Bath, 2001). Some patients intentionally avoid information that may cause them anxiety or stress, a behavior characterized as “blunting,” in opposition to “monitoring” or active information seeking (Folkman & Lazarus, 1980; Miller, 1987; Rees & Bath, 2001). For example, one third of patients in a study reported avoiding or distracting themselves from health information when they felt that the outcome could not be altered (Miller, 1987).

A recent analysis of national survey data showed that almost one third (31%) of people with a history of cancer responded negatively to the question of whether or not they had looked for information about cancer (Ramanadhan & Viswanath, 2005). This is particularly striking given the complexity of decision making following a cancer diagnosis and the intricate demands placed on patients for making treatment decisions. Moreover, the amount of cancer information in the environment is steadily growing, placing even

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greater demands on patients to sift through and evaluate information (Viswanath, 2005).

The finding that large numbers of cancer patients do not seek health information despite a serious diagnosis raises the question of who does and who does not seek health information and with what consequences. This question is critical to explore given the well-documented disparities in health between higher and lower socioeconomic groups and among different racial and ethnic groups (Agency for Healthcare Research and Quality, 2005; Institute of Medicine, 2003). Disparities in health care and health outcomes parallel documented inequalities in communication characterized by differences in access to communication sources, processing and retention of information, and the ability to act on it (Viswanath, 2006). Given the deep divides among different social classes and ethnic and racial groups in health, and in communication, it is critical that we understand who the information nonseekers are in an effort to develop appropriate strategies to reach them.

This article attempts to develop a profile of nonseekers of information, determine how they are different from active information seekers, and study possible determinants of nonseeking behaviors. In addition, drawing from illustrative data we assess whether their nonseeking status is also reflected in the attention paid to and trust in health information in the media as well as in preventive health behaviors such as smoking, physical activity, and diet.

BACKGROUND AND SIGNIFICANCE

In general, individuals may learn about a health topic in a number of ways. At one end of the continuum is casual or incidental exposure to information that people are likely to come across in their routine use of media or in conversations with people in their networks. Such adventitious exposure to information on a topic could lead to learning as has been documented in a number of studies (Hornik, 2002; Robinson & Mark, 1986). Of course, such exposure and learning are not always uniform and gaps in information exposure and learning have been extensively documented (Viswanath & Finnegan, 1996). On the other end of the continuum is purposive and deliberate seeking of information on a topic primarily because of its salience and need. In such cases, motivation and salience could lead to higher learning among information seekers compared to nonseekers. Information seeking connotes a degree of volition on the part of the seeker in contrast to incidental or casual exposure.

Information Seeking and Its Correlates With Cancer as an Exemplar

Information seeking can be triggered by any number of factors, including the individual's communication and interpersonal skills, knowledge about cancer, desire to participate ac-

tively in the decision-making process, cognitive function, and level of emotional distress (Johnson, 1997; Pinquart & Duberstein, 2004). Also, key sociodemographic characteristics such as age, gender, race or ethnicity, and socioeconomic status (SES) influence information seeking. Overall, younger patients tend to seek out more cancer information (and from a broader array of sources) than older patients, however it is important to note that both groups report interest in being well-informed (Finnegan, Viswanath, Kahn, & Hannan, 1993; Jenkins, Fallowfield, & Saul, 2001; Maly, Umezawa, Leake, & Silliman, 2004; McIllmurray et al., 2001; Pinquart & Duberstein, 2004). Women tend to be more active seekers of health information in general and of cancer specifically (Boudioni et al., 1999; Eysenbach, Sa, & Diepgen, 1999; Manfredi, Czaja, Buis, & Derk, 1993). Certain racial and ethnic groups, such as African Americans, are thought to be less active information seekers, but mixed results are found once other sociodemographic variables are controlled for (Matthews, Sellergren, Manfredi, & Williams, 2002).

Information seeking impacts cancer patients' outcomes in a number of ways. The more informed patients participate in decision making and report greater satisfaction with treatment approaches, which in turn is significantly associated with higher emotional, social, and cognitive functioning, and lower reports of side effects (Luker et al., 1995; Schou, Ekeberg, Sandvik, Hjermsstad, & Ruland, 2005). Well-informed patients are also better able to cope with the diagnosis, treatment, and survivorship phases and also with the effects of these phases on quality of life (Rutten, Arora, Bakos, Aziz, & Rowland, 2005).

Patients and their families often cite physicians and friends as their preferred sources of information (Chalmers, Marles, Tataryn, Scott-Findlay, & Serfas, 2003; Norum, Grev, Moen, Balteskard, & Holthe, 2003; Rees & Bath, 2000). However, patients increasingly are paying more attention to cancer information provided by professional societies, libraries, others in their social networks, and the Internet, and the choice of sources is mediated by gender, age, and education (Carlsson, 2000; Freimuth, 1993; Rutten et al., 2005; Satterlund, McCaul, & Sandgren, 2003; Serin et al., 2004). A review of published research from 1980 to 2003 found that preferred sources varied by stage in the treatment process. Patients in the diagnosis and treatment phases tended to rely on print media and information from health professionals, whereas those in the posttreatment phase relied on providers and interpersonal contacts for information (Rutten et al., 2005).

As discussed a great deal in the popular press, the Internet may be a significant source of health information. A meta-analysis of studies of cancer patients using the Internet concluded that about 39% of those with cancer are using the Internet, but, more important, another 15% to 20% are accessing resources via family and friends (Eysenbach, 2003).

Despite reports of active information seeking by individuals, either through their own efforts or through their social

networks, some do not obtain information except for what they may obtain from their providers. In a recent study of women with breast cancer, focus group participants who did not seek out information noted that they did not want to worry, were frightened, or felt that information was negative and depressing (Rees & Bath, 2001). A series of focus groups also suggested that three coping strategies existed among a group who wanted to be informed but did not want extensive information about their disease and treatment. These strategies were faith in the providers' expertise, a sense of hope, and a sense that information resources were scarce and needed to be shared with other patients (Leydon et al., 2000).

Trust in health information gained from a variety of sources is also an important driver of information seeking. As with other aspects of the patient-provider relationship, trust in the provider impacts the information exchange greatly. An environment allowing for participatory decision making and information sharing is often accompanied by, and may depend on, high levels of trust between the patient and provider (Kraetschmer, Sharpe, Urowitz, & Deber, 2004). As mentioned earlier, patients often also turn to individuals in their social networks for information partly because of trust, an observation widely discussed in social capital literature (Berkman & Glass, 2000; Kawachi, Kim, Coutts, & Subramanian, 2004; Viswanath, Randolph, & Finnegan, 2006). We also know that cancer patients are interested in gaining information from the Internet, provided that the source is a reputable Web site (LaCoursiere, Knobf, & McCorkle, 2005).

Other important drivers of information seeking regarding cancer are the beliefs the individual has about cancer diagnosis, treatment, and survivorship. For example, fatalism is often cited as a barrier to diagnosis and treatment among many individuals, particularly African Americans and Hispanic Americans (Reynolds, 2004; Wolff et al., 2003). A recent study of African Americans' perceptions of colorectal cancer found a disturbing theme—the notion that screening and treatment procedures may be wasted effort and that surgery may result in the spread of the cancer (Greiner, Born, Nollen, & Ahluwalia, 2005). One would expect that individuals who perceive action in this area to be futile would not be motivated to seek health information.

Information Seeking and Communication Inequalities

Members of higher SES groups tend to seek more information and use a greater range of sources than those of lower SES (Eakin & Strycker, 2001). It is more valuable, however, to put information seeking in the larger context of communication inequality. Communication inequality may be defined as disparities among social classes and racial and ethnic groups in access to and use of information channels, attention to health content, recall, knowledge, and comprehension of health information, and capacity to act on relevant information

among individuals (Viswanath, 2006; Zobel, Ramanadhan, & Viswanath, 2006). One might suggest that information seeking is a critical dimension along the pathway from access to information and use of media to a capacity to act on the information. In fact, information seeking may be an antecedent of use and access and other subsequent outcomes. Active seekers, one might posit, are likely to look for information through active use of media, and subsequently recall and retain more information, which may enhance their capacity to act on that information. In short, deliberate seeking of information could stem the emergence of inequalities or bridge them if they exist. And, last, if there are differences in degrees of seeking information, then those differences may constitute a part of communication inequalities and contribute to health disparities.

Accordingly, our goal with this article is to understand the nonseekers, who for various reasons do not look for information at times at which it would be expected.

METHOD

Data for this study come from the Health Information National Trends Survey, a survey of American adults conducted by the National Cancer Institute in 2003 (Nelson et al., 2004). The data are based on a probability sample of all households with a telephone in the United States, combined with the most recent birthday method for selection of one adult per household. African Americans and Hispanic Americans were oversampled to increase representation of both groups. Interviews were administered in English and Spanish using a computer-assisted telephone interviewing system. A total of 6,369 interviews were completed, yielding a final household response rate for the household-level screening of 55%. The analysis focuses on the 6,133 individuals with complete data regarding cancer history and information-seeking status.

The variables of interest were SES indicators such as education level and income, report of information seeking (both by the patient and his or her contacts), history of cancer, beliefs regarding cancer, experiences with provider, attention to health information, trust in health information sources, and general preventive health behaviors.

Respondents were first grouped by information-seeking pattern, which was measured by two questions. Respondents were asked, "Did you ever seek cancer information from any source?" A second question probed, "Excluding your doctor or other health care provider, has someone else ever looked for information about cancer for you?" Those who reported that they had neither looked for cancer information nor received information from a non-health care provider were categorized as *nonseekers*. Individuals who reported searching for cancer information or receiving it from contacts besides their provider were categorized as *seekers*. Within these groups, individuals were further classified based on their response to the question, "Have you ever been told by a doctor

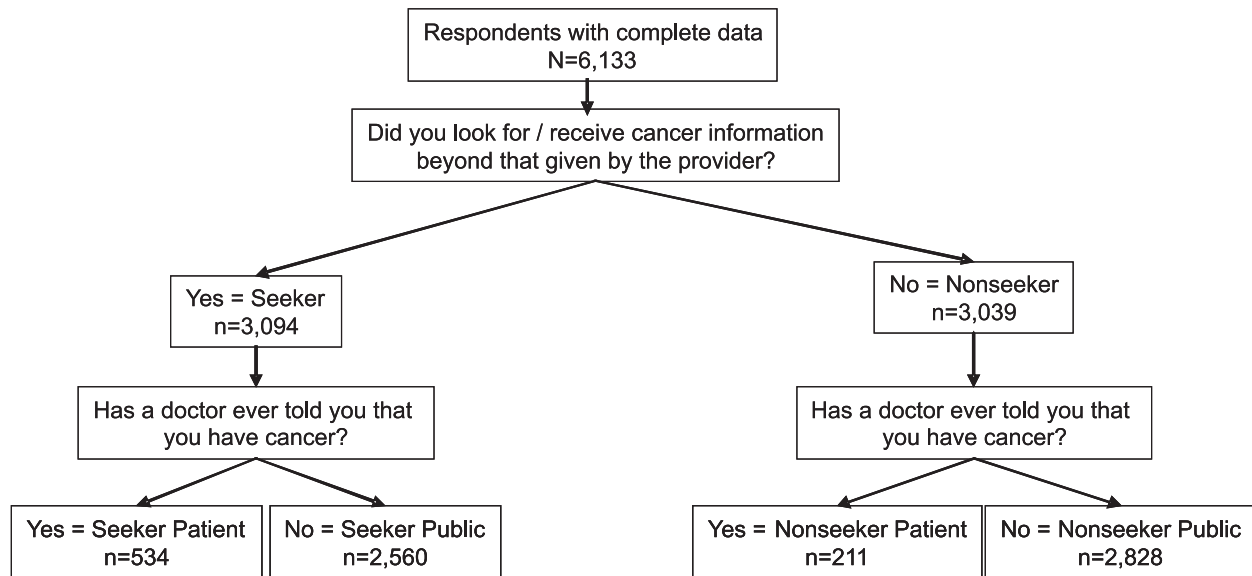


FIGURE 1 Categorization schematic describing four groups of interest.

that you had cancer?" Those who reported a history of cancer were termed *patients* and those without a history of cancer were termed the *public*. Thus, we have four groups in the analysis: seeker patients, the seeker public, nonseeker patients, and the nonseeker public (see Figure 1).

We used a number of sociodemographic variables to profile the four groups, including age, sex, race or ethnicity, language of the interview, education, marital status, annual household income, health status, insurance status, and employment status. For those with a history of cancer, we also tracked age at diagnosis and year of diagnosis.

To assess beliefs about cancer, respondents were asked, "Can you think of anything people can do to reduce their chances of getting cancer?" With regard to their experiences with providers, such as being listened to or involved to a sufficient degree, respondents were asked, "During the past 12 months, how often did doctors or other health care providers [listen carefully to you/explain things in a way you can understand/show respect for what you had to say/spend enough time with you/involve you in decision]? Would you say always, usually, sometimes, or never?" Attention to cancer information from sources such as television, radio, newspapers, magazines, and the Internet was measured by asking, "How much attention do you pay to information about health or medical topics on [source]? Would you say a lot, some, a little, or not at all?" Similarly, trust in these information sources was measured by asking, "How much would you trust the information about cancer from [source]?" The responses were classified as "a lot or some" as opposed to "a little or not at all."

Last, for general health behaviors, respondents were asked about their fruit and vegetable consumption: (a) "During the past month, how often did you eat fruit? Include fresh, canned, or frozen fruit"; (b) "During the past month, how of-

ten did you eat vegetables? Include things like salad, cooked dried beans, corn, and broccoli." Smoking history was assessed by asking, "Have you smoked at least 100 cigarettes in your entire life?" Individuals who responded in the affirmative were then asked, "Do you now smoke cigarettes every day, some days, or not at all?" Individuals giving the first two responses were classified as current smokers. Last, self-report of respondents' height and weight was used to calculate their body mass indexes (BMIs). Respondents with a BMI between 25 and 30 kg/m² were classified as overweight and those with a BMI greater than 30 were classified as obese. Descriptive analyses were used to profile the four groups and bivariate analyses through chi-squares were used to test the statistical differences across the groups.

RESULTS

We first examined the sociodemographic profiles of the four groups: nonseeker patients, the nonseeker public, seeker patients, and the seeker public, and found that the groups have dissimilar profiles. In fact, we found that there is a strong socioeconomic gradient among our groups. Nonseeker patients tend to have the lowest income, followed by the nonseeker public, seeker patients, and the seeker public, and the differences are statistically significant. Trends due to schooling are similar in that the nonseeker patients' educational attainment is considerably lower than the nonseeker public, followed by seeker patients and the seeker public. Putting cancer history aside for a moment, we see that nonseekers have lower income and education levels than seekers. In sum, education and income appear to strongly influence information-seeking and -nonseeking status among both cancer survivors and the public.

TABLE 1
Demographic Profile of the Four Groups of Interest (Percentages).

Characteristic	Nonseeker Patients ^a	Nonseeker Public ^b	Seeker patients ^c	Seeker Public ^d
Income*				
<\$15,000	16.11	12.45	10.30	7.81
\$15,000–\$34,999	35.55	31.22	30.52	24.92
\$35,000–\$49,999	12.80	16.05	14.79	15.55
\$50,000–\$74,999	9.00	13.40	15.17	18.55
\$75,000 +	6.61	15.81	19.29	25.27
Education*				
<High school	21.33	17.70	7.68	6.53
High school	38.39	34.51	30.90	23.63
Some college	21.33	24.49	26.22	29.58
College graduate	18.95	23.60	35.21	40.26
Race/ethnicity*				
White	82.94	71.25	87.27	76.64
African American	6.64	13.26	6.93	12.23
Other	7.09	6.94	5.8	9.53
Hispanic ethnicity*				
Hispanic	7.11	17.19	4.31	9.34
Non-Hispanic	91.00	82.11	95.32	90.08
Language of interview				
English	96.68	90.84	98.13	97.70
Spanish	3.32	9.16	1.87	2.30
Retired*	53.55	17.54	33.58	11.98
Mean age (years)*	66.64	47.09	57.80	44.87
Mean age (years) at diagnosis*	53.13	N/A	46.97	N/A
Short-term survivor (≤5 years)	35.07	N/A	38.20	N/A

^a*n* = 211. ^b*n* = 2,828. ^c*n* = 534. ^d*n* = 2,560.

**p* < 0.05.

We did not find differences in information seeking between African Americans and Whites, but the data in Table 1 show that Hispanic Americans in our sample are more likely to be nonseekers of cancer information compared to non-Hispanic Americans. Age is significantly associated with information seeking: Nonseekers as a group are older and were also diagnosed at an older age, as expected. We found a difference of 6 years, on average, between nonseeker and seeker patients.

Beliefs Regarding Cancer

Respondents were also asked about their fatalistic beliefs regarding cancer. When asked whether anything can be done to reduce the risk of cancer, larger numbers of nonseekers responded that there is nothing one can do to reduce the risk of getting cancer compared to seekers. In fact, 20% of nonseeker patients and 18% of the nonseeker public gave this response, compared to 13% of seeker patients and 9% of the seeker public. The differences between groups are statistically significant (*p* < .05).

Interactions With Providers

We wondered whether nonseekers of information are satisfied with their health care providers and feel that they do not need to seek additional information. While we could not test satisfaction, the responses to items on experiences with pro-

viders based on the Consumer Assessment of Healthcare Providers and Systems survey are instructive (Table 2). Nonseeker patients were more likely to answer that their providers listened carefully, showed respect to them, and spent enough time with them compared to all other groups. It is possible that nonseekers (with and without a history of cancer) are relatively more satisfied with their providers, whereas both groups of seekers are less likely to feel so.

We expected to see that information seeking is correlated with attention to health information in the media whether the exposure is intentional or incidental. One corollary for this general expectation focuses on whether diagnosis with a serious disease could potentially lead to greater attention to health. If so, we may expect that people with a history of cancer, even if they do not actively seek information, may at least pay more attention to health content in the media. The data demonstrate that information seeking is strongly associated with attention, as expected. Yet, counter to our expectations, diagnosis with a disease does not seem to engender greater attention to health content. The association between information seeking and attention to health in the media holds consistently across all media, with nonseeker patients paying the least attention, followed by the nonseeker public, seeker patients, and the seeker public (*p* < .05; data not shown). The pattern is particularly pronounced with the Internet; almost four times as many members of the seeker public report paying “a lot or some” at-

TABLE 2
Experiences With Practitioners, by Group. Percentage Responding “Always” to Questions About Experiences With Providers

Question	Nonseeker Patients ^a	Nonseeker Public ^b	Seeker Patients ^c	Seeker Public ^d
In the last 12 months, how often did your provider ...				
Listen carefully to you*	72.19	65.53	60.83	61.40
Explain things in a way you could understand	68.65	64.87	61.54	63.72
Show respect for what you had to say*	80.00	74.91	69.55	70.34
Spend enough time with you*	67.03	60.43	56.69	51.94
Involve you in decisions about your health care as much as you wanted	69.83	64.61	65.93	62.87

^an = 187. ^bn = 2,147. ^cn = 508. ^dn = 2,215.
*p < 0.05.

attention to cancer information on the Internet, compared to nonseeker patients. The exception is for newspapers, to which nonseeker patients report a higher level of attention than the nonseeker public, but information seekers still report greater attention.

Potential reasons for not actively seeking health information are many, including personal, situational, psychological, and structural factors. The data in Figure 2 offer one possible reason for nonseeking status: Nonseeker patients, and nonseekers in general, place their trust in doctors more than any other source of information. This could be one reason for nonseeking status, that is, a limited trust in nonmedical sources of information. As the data in Figure 2 show, all four groups trust information from doctors. But the commonality ends when other sources are taken into account. At one end of the spectrum is the seeker public, who appear to trust a variety of information sources in addition to the doctors. At the other end are nonseeker patients, who are less likely to trust any source other than a doctor. For example, about 32% of the nonseeker patients reported that they have “a lot or some”

trust in cancer information on the Internet, compared to almost 77% of the seeker public and about 72% of seeker patients. The patterns are similar for radio, magazines, and newspapers, though not as pronounced.

Information seeking has consequences if it leads to both objective and subjective changes in health outcomes, whether negative or positive. Such a test requires longitudinal data that were not available in this dataset. The best approximation is to examine the association between information seeking and health behaviors as reported in Table 3. While the differences are modest, the data show that information seeking among respondents, both among cancer patients and nonpatients, is associated with greater consumption of fruits and vegetables. Similarly, more nonseekers reported that they are less likely to be physically active compared to information seekers. This fits with the finding that overweight and obesity are present at higher rates among nonseeker patients than other groups. There are no statistically significant differences in smoking prevalence among the groups.

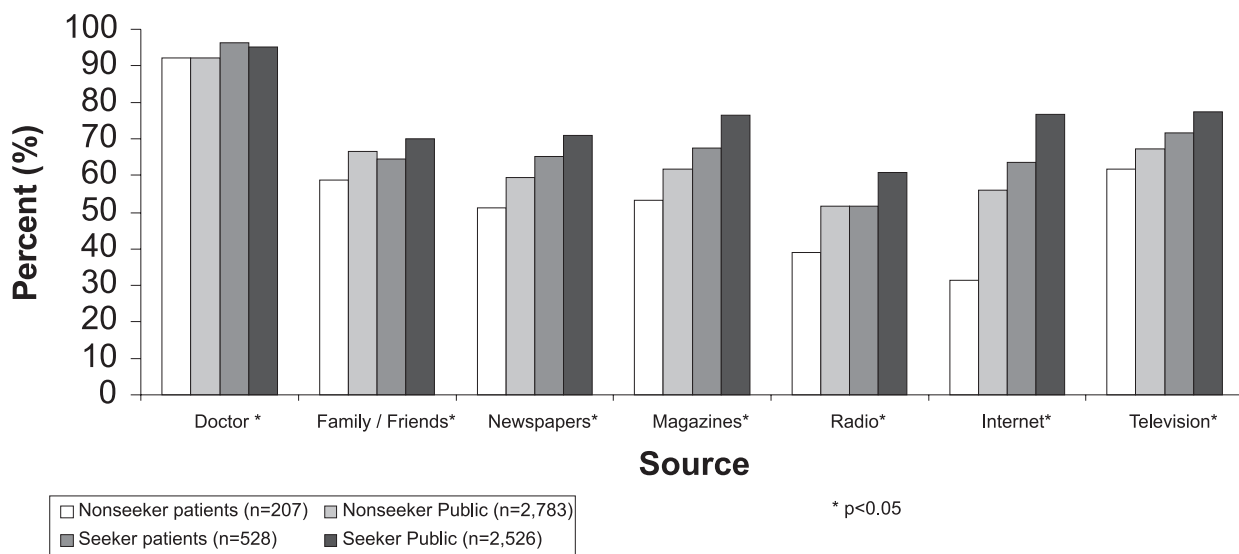


FIGURE 2 Percentage reporting “A lot or some” trust in cancer information on various mass media channels, by group.

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TABLE 3
General Health Behaviors and BMI, by Group

Behavior	Nonseeker Patients ^a			Nonseeker Public ^b			Seeker Patients ^c			Seeker Public ^d		
	M	SD	%	M	SD	%	M	SD	%	M	SD	%
Daily fruit/vegetable consumption: Number of servings**	2.27	1.47		2.03	1.41		2.44	1.51		2.38	1.60	
Reporting physical activity in last month**			65.73			68.28			75.20			78.22
Reporting regular exercise weekly**			39.33			64.68			57.06			71.96
Currently smoking			13.97			18.38			19.64			16.77
Overweight*			38.37			34.25			33.13			30.33
Obese*			24.42			23.49			22.29			23.21

Note. BMI = body mass index.

^an = 179. ^bn = 2,088. ^cn = 496. ^dn = 2,160.

*p < 0.10. **p < 0.05.

DISCUSSION

It is now widely accepted that chronic diseases, such as cardiovascular disease, diabetes, hypertension, and cancer, among others, are associated with lifestyle patterns and that modification and interventions to change these lifestyle patterns may have a pronounced influence on disease trajectories. For example, almost a third to half of cancer cases are preventable with appropriate modifications in lifestyle through interventions (Colditz, DeJong, Hunter, Trichopoulos, & Willett, 1996; Stein & Colditz, 2004). Communication plays a critical role in health promotion and disease prevention in a variety of risk factors associated with chronic diseases, such as cardiovascular disease, alcohol consumption, tobacco use, energy balance, and drug abuse (Donohew, Palmgreen, & Lorch, 1994; Hornik, 2002; Johnson, 1997; Viswanath & Finnegan, 2002; Worden & Flynn, 2002), and along all stages of the cancer control continuum (Hiatt & Rimer, 1999; Viswanath, 2005). The importance of information and communication have become even more critical with the proliferation of information channels as well as health content in the media (Viswanath, 2006). There is an increased need for technical background to understand increased choices for treatment options and the related movement toward shared and informed decision making between providers and patients (Rimer et al., 2004).

These assumptions about the positive role of communication are premised on exposure to information either incidentally or through active seeking. It is this latter construct, information seeking, that has attracted our attention based on the assumption that health is a domain that engages most people's attention given its personal or social salience. Yet, as we reported elsewhere, almost one third of people with a history of cancer—a group of particular focus in this article—reported that they did not seek cancer information (Ramanadhan & Viswanath, 2005). While exposure to health information and use of media to obtain health information has been widely studied, little attention has been paid to characterizing the group that chooses not to actively seek health information.

The cross-sectional nature of our data limits our ability to predict the causal direction, but our data tell a simple and straightforward story. Socioeconomic status is a significant correlate of information seeking. Those with higher education and higher income are much more likely to be health information seekers compared to those with less education and with lower income. The older age group is less likely to actively look for health information. The mean age for diagnosis of cancer for nonseekers is higher than for seekers.

Our findings point two potential sources of explanation for the nonseeking status. The nonseekers report more positive experiences with their providers compared to other groups. Second, nonseekers place most trust in doctors as a source of information but trust other sources much less. Information seekers, on the other hand, trust a variety of information sources, including doctors. The greater diversity of sources and trust in sources could potentially explain why information seekers are active in decision making; satisfaction with their treatment choices and lower report of side effects suggests the importance of provision of information to nonseekers to promote informed decision making and more satisfying treatment choices and quality of life.

Information-seeking status matters, in terms of communication choices, knowledge, and behavior patterns. Information seeking is strongly associated with attention to health information across a range of media, which is important because attention to media is a robust predictor of health knowledge (Kosicki & McLeod, 1990; Viswanath, Breen, et al., 2006; Viswanath & Finnegan, 1996). In addition to having lower attention and likely lower knowledge, nonseekers are also less likely to maintain a healthy lifestyle. They reported lower consumption of fruits and vegetables, have a more sedentary lifestyle, and are slightly more obese. In short, information seeking is a strong correlate of a healthy lifestyle.

If confirmed in other research, these findings suggests that promoting information seeking or provision of information to nonseekers could stem the emergence of communication and health inequalities or bridge them if they exist. The data

in this study suggest potential avenues for intervention. For example, because nonseekers reported positive experiences with providers, is it possible to use providers' offices to disseminate needed information to nonseekers? How do we design systems that can provide needed information to nonseekers in places that they trust?

Nonseekers are of great interest because they are the least proactive group and may be the most difficult to reach via conventional channels. Some nonseekers may be information avoiders, but some may simply not have had the opportunity or ability to find information, so a first step is to further profile these individuals and determine whether or not there is a gap between their information needs and what information they are able to find. This profile of nonseekers also offers an opportunity to describe their beliefs and behaviors and identify potential avenues to intervene even when do they not seek information. Paying greater attention to nonseekers becomes even more important given the importance of information in clinical decision making in a world that is increasingly demanding greater technical knowledge to make optimal decisions.

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