Bayesian Modeling, Inference, Prediction and Decision-Making

1: Background and Basics

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Short Course (sponsored by eBay and google)

10 Fridays, 11 Jan-22 Mar 2013 (except 25 Jan)

course web page
www.ams.ucsc.edu/∼draper/eBay-2013.html

Preface

This material provides a **thorough introduction** to (or **review** of) **basic methodological ideas** and **applications** in **Bayesian modeling, inference, prediction and decision-making**, based on a **series** of **case studies** and **assuming no previous exposure** to **Bayesian ideas or methods**.

The **case studies** will be drawn from **medicine** (**diagnostic screening** for **HIV**; hospital-specific **prediction** of **patient-level mortality**; hospital **length of stay** for **premature births**; a **randomized controlled trial** of **in-home geriatric assessment**; a **meta-analysis** of **aspirin** to **reduce mortality** after a **heart attack**), **education** (a **meta-analysis** of **teacher expectancy**) and the **physical sciences** (**measurement** of **physical constants**), and the **course** will **conclude** with one or more **case studies** drawn from **problems** of **immediate relevance** to **eBay technical staff** and **other researchers** in the **Bay Area tech community**.

The **course** is **intended mainly** for **people** who **often (or at least sometimes) use statistics in their research**; some **undergraduate** or **graduate coursework in probability and/or statistics** will provide **sufficient mathematical background** for **participants**.

Preface (continued)

To **get** the **most** out of the **course**, ideally you should be **comfortable** with **hearing** me **mention** (at least briefly) (a) **differentiation** and **integration** of **functions of several variables** and (b) **discrete** and **continuous probability distributions (joint, marginal**, and **conditional**) for **several random variables** at a time, but **all necessary concepts** will be **approached** in a sufficiently **intuitive manner** that **rustiness** on these **topics** will **not prevent understanding** of the **key ideas**.

Extensive **details** required for **carrying out** the **analyses** are provided below, including **hardcopy** of a **number** of **sessions** with a frequently-used **freeware statistical computing** package (`R`), a leading **symbolic computing** package (`Maple`), and a **freeware package** for **fitting Bayesian models** (`WinBUGS`).

Text files containing `Maple`, `R` and `WinBUGS` **code** and **data sets** will be **posted** on the **course web page** (the **URL** is on **page 1**).

Homework problems and **solutions** will also be **provided**, to give you a **chance** to **further explore** the **ideas** we'll look at (if you have **time**).

Preface (continued)

I **propose** the following **schedule** for **each day**:

9–10am	**session 1**
10–10.15am	break
10.15–11.15am	**session 2**
11.15–11.30am	break
11.30am–12.30pm	**session 3**
12.30–1.30pm	lunch
1.30–2.30pm	**session 4**
2.30–2.45pm	break
2.45–3.45pm	**session 5**
3.45–4pm	break
4–5pm	**session 6**

Some of these **sessions** will be devoted to **new material**, some to **solving problems**, some to **computer labs**.

`Maple` and `R` are **available** for a **variety** of **operating systems**; `WinBUGS` (as the **name implies**) is a `Windows` program, although an **open-source project** called `OpenBUGS` has made some **progress** toward **porting** `BUGS` to **other platforms**.

An Example, to Fix Ideas

Example (Krnjajić, Kottas, Draper [KKD] 2008): *In-home geriatric assessment (IHGA)*. In an **experiment** conducted in the **1980s** (Hendriksen et al. 1984), **572 elderly people**, **representative** of $\mathcal{P} =$ {all **non-institutionalized elderly people** in **Denmark**}, were **randomized**, **287** to a **control** (C) group (who received **standard health care**) and **285** to a **treatment** (T) group (who received **standard care plus IHGA**: a kind of **preventive medicine** in which each person's **medical** and **social needs** were assessed and acted upon **individually**).

One **important outcome** was the **number of hospitalizations** during the **two-year** life of the study:

	Number of Hospitalizations						
Group	0	1	...	k	n	Mean	SD
Control	n_{C0}	n_{C1}	...	n_{Ck}	$n_C = 287$	$\bar{y}_C$	s_C
Treatment	n_{T0}	n_{T1}	...	n_{Tk}	$n_T = 285$	$\bar{y}_T$	s_T

Let μ_C and μ_T be the **mean hospitalization rates** (per two years) in $\mathcal{P}$ under the C and T **conditions**, respectively.

Here are **four statistical questions** that **arose** from **this study**:

The Four Principal Statistical Activities

Q_1: Was the **mean number of hospitalizations per two years** in the IHGA group **smaller** than that in **control** by an **amount** that was **large** in **practical** terms? $\left[\textbf{description} \text{ involving } \left(\frac{\bar{y}_T - \bar{y}_C}{\bar{y}_C}\right)\right]$

Q_2: Did IHGA **reduce** the **mean number of hospitalizations per two years** by an **amount** that was **large** in **statistical** terms? $\left[\textbf{inference} \text{ about } \left(\frac{\mu_T - \mu_C}{\mu_C}\right)\right]$

Q_3: On the **basis** of **this study**, how **accurately** can You **predict** the **total decrease** in **hospitalizations** over a period of N years if **IHGA** were **implemented throughout Denmark**? **[prediction]**

Q_4: On the **basis** of **this study**, is the **decision** to **implement IHGA** throughout Denmark **optimal** from a **cost-benefit** point of view? **[decision-making]**

These questions **encompass** almost all of the **discipline** of **statistics**: **describing** a **data set** D, **generalizing outward inferentially** from D, **predicting new data** D^*, and helping people **make decisions** in the **presence** of **uncertainty** (I include **sampling/experimental design** under **decision-making**; **omitted**: data **quality assurance (QA)**, ...).

Quantification of Uncertainty

Quantification of uncertainty: **Classical**, **frequentist** and **Bayesian definitions** of **probability**.

Case study: **Diagnostic screening** for **HIV**

Widespread **screening for HIV** has been proposed by **some people** in **some countries** (e.g., the **U.S.** in 1985).

Two **blood tests** that **screen** for **HIV** are **widely available**: *ELISA*, which is **relatively inexpensive** (roughly \$20) and **fairly accurate**; and *Western Blot (WB)*, which is **considerably more accurate** but **costs quite a bit more** (about \$100).

A **new patient** comes to **You**, a **physician**, with **symptoms** that suggest he may be **HIV positive** (Good, 1950: **You** = a **generic person** wishing to **reason sensibly** in the presence of **uncertainty**).

Questions

- Is it **appropriate** to use the **language** of **probability** to **quantify Your uncertainty** about the **true/false proposition**
$A = \{\text{this patient is HIV positive}\}$?

Definition of Statistics

Questions

- If so, **what kinds of probability** are **appropriate**, and how would You **assess** $P(A)$ in each case?

- What **strategy** (e.g., *ELISA*, *WB*, both?) should You **employ** to **decrease Your uncertainty** about A?

If **You decide** to run a **screening test**, how should **Your uncertainty** be **updated** in light of the **test results**?

Statistics might be **defined** as **the study of uncertainty: how to measure it well, and how to make good choices in the face of it**, and **probability** as the part of **mathematics** devoted to the **quantification of uncertainty**.

The **systematic study** of **probability** is **fairly recent** in the **history of ideas**, dating back to about **1650** (e.g., Hacking, 1975).

Definitions of Probability

In the last **350** years **three main ways to define probability** have arisen (e.g., Oakes, 1990):

- **Classical** (Pascale, Fermat): **Enumerate** the **elemental outcomes** (EOs) in a way that makes them **equipossible** on, e.g., **symmetry** grounds, and compute $P_C(A)$ = the ratio of n_A =(number of EOs **favorable** to A) to n =(**total number** of EOs).

- **Frequentist** (Venn, von Mises): **Restrict attention** to **attributes** A of **events**: phenomena that are **inherently repeatable** under **"identical" conditions**; define $P_F(A)$ = the **limiting** value of the **relative frequency** with which A **occurs** as the **number of repetitions** $\to \infty$.

- **Personal**, or **"Subjective,"** or **Bayesian**: two **equivalent definitions**:

— (Bayes, de Finetti) Imagine **betting with someone** about the **truth** of the **proposition** A, and **ask Yourself** what **odds** O_{You} (in favor of A) You would need to **give or receive** in order that You **judge** the bet to be**fair**; then (for You) $P_{B:\text{You}}(A) = \frac{O_{\text{You}}}{(1+O_{\text{You}})}$.

Pros and Cons

— (Laplace, RT Cox, Jaynes) $P_{B:\text{You}}(A)$ is a **numerical measure** of the **weight of evidence** in favor of **proposition** A, based on Your current **information**, and required to **satisfy** a set of reasonable **axioms** to achieve **internal logical consistency**.

Other approaches not covered here include **logical** (Keynes, Jeffreys, Carnap) and **fiducial** (Fisher) **probability**.

Each of these **probability definitions** has general **advantages** and **disadvantages**:

- **Classical:** Plus: **Simple**, when applicable (e.g., **idealized coin-tossing**, drawing **colored balls** from **urns**, ...).

- **Classical:** Minus: The only way to define **"equipossible"** without a **circular appeal** to **probability** is through the **principle of insufficient reason** — You judge EOs **equipossible** if You have **no grounds** (**empirical**, **logical**, or **symmetrical**) for **favoring** one over another — but this leads to **paradoxes** (e.g., assertion of **equal uncertainty** on an **infinite set** is **not invariant** to the **choice** of **scale**).

Pros and Cons (continued)

- **Frequentist:** Plus: **Mathematics** relatively **tractable**.

- **Frequentist:** Minus: Only applies to **inherently repeatable events**, e.g., (as of November 2011) P_F(Barack Obama will be **re-elected** in 2012) is (strictly speaking) **undefined**.

- **Bayesian:** Plus: **All forms of uncertainty** are **in principle quantifiable** with this approach.

- **Bayesian:** Minus: There's **no guarantee** that the **answer** You get by **querying Yourself** about **betting odds** or **weight of evidence** will **retrospectively** be seen by **You** or **others** as **"good"** (but how should the **quality** of an **uncertainty assessment** itself be **assessed**?).

Application to HIV Screening

$P(A) = P($**this patient** is HIV-positive$) =?$

Data are available from **medical journals** on **prevalence** of **HIV-positivity** in various **subsets** of $\mathcal{P} = \{$all humans$\}$ (e.g., it's **higher** in **gay people**, and **lower** in **older people**).

Probability Modeling is Judgmental

All three probabilistic approaches require You to use Your **judgment** to identify the **recognizable subpopulation** $\mathcal{P}_{\text{this patient}}$ (Fisher, 1956; Draper et al., 1993): this is

> *the* **largest subset** *to which* **this patient belongs** *for which the* **HIV prevalence** *differs from that in the rest of* $\mathcal{P}$ *by an amount You judge as* **large enough to matter in a practical sense**.

Within $\mathcal{P}_{\text{this patient}}$ You regard **HIV prevalence** as **close enough to constant** that the **differences** are **not worth bothering over**, but the **differences** between **HIV prevalence** in $\mathcal{P}_{\text{this patient}}$ and its **complement matter** to You.

Here $\mathcal{P}_{\text{this patient}}$ might consist of **everybody** who **matches** this patient on (e.g.) **gender**, **age** (category, e.g., 25–29), and **sexual orientation**.

NB This is a **modeling choice** based on **judgment**; **different reasonable people** might make **different choices**; thus **probability modeling** in the **real world** is **inherently subjective** (see **page 15** below for **more details**).

The Three Probability Definitions in Practice

As a **classicist** You would then (a) use this **definition** to **establish equipossibility** within $\mathcal{P}_{\text{this patient}}$, (b) **count** $n_A =$ (the number of HIV-positive people in $\mathcal{P}_{\text{this patient}}$) and $n =$ (the total number of people in $\mathcal{P}_{\text{this patient}}$), and (c) compute $P_C(A) = \frac{n_A}{n}$.

As a **frequentist** You would (a) equate $P(A)$ to $P($a person chosen **at random with replacement** (i.e., **independent identically distributed** (**IID**) sampling) from $\mathcal{P}_{\text{this patient}}$ is HIV-positive), (b) imagine **repeating** this **random sampling** indefinitely, and (c) **conclude** that the **limiting value** of the **relative frequency** of **HIV-positivity** in these **repetitions** would also be $P_F(A) = \frac{n_A}{n}$.

NB Strictly speaking You're **not allowed** in the **frequentist approach** to talk about $P($**this patient** is **HIV-positive**$)$: either he **is** or he **isn't**; in the **frequentist paradigm**, You can **only** talk about the **process** of **sampling people like him** from $\mathcal{P}_{\text{this patient}}$.

As a **Bayesian**, with the **information** given here You would **regard** this patient as **exchangeable** (de Finetti, e.g., 1964, 1974/5) with **all other patients** in $\mathcal{P}_{\text{this patient}}$ — meaning informally that **You judge Yourself**

Exchangeability and Coherence

equally uncertain about **HIV-positivity** for **all the patients** in this **set** — and this **judgment**, together with the **axioms** of **coherence**, would also yield $P_{B:\text{You}}(A) = \frac{n_A}{n}$ (although I've not yet said **why** this is so).

Exchangeability and **coherence** will be **defined** and **explored** in **more detail** in what follows.

Note that with the **same information base** the **three approaches** in this case have led to the **same answer**, although the **meaning** of that answer **depends on the approach**, e.g., **frequentist probability** describes the **process** of **observing a repeatable event**, whereas **Bayesian probability** is an attempt to **quantify Your uncertainty** about something, **repeatable or not**.

The **classical** and **frequentist approaches** have sometimes been called **"objective"**, whereas the **Bayesian approach** is clearly **subjective**, and — since **objectivity** sounds like a **good goal** in **science** — this has sometimes been **used as a claim** that the **classical** and **frequentist approaches** are **superior**.

"Objectivity" and Subjectivity

I'd argue, however, that in **interesting applied problems** of **realistic complexity**, the **judgment** of **equivalence** or **similarity** (**equipossibility, IID, exchangeability**) that's **central** to all three theories **makes them all subjective in practice**.

Imagine, for example, that You were given **data on HIV prevalence** in a **large group of people**, along with **many variables** (possible **predictors**) that **might or might not be relevant** to identifying the **recognizable subpopulations**.

You and other **reasonable people** working **independently** might well **differ** in your **judgments** on **which of these predictors are relevant** (and **how** they should be **used** in making the **prediction**), and the **result** could easily be **noticeable variation** in the **estimates** of $P(\text{HIV positive})$ obtained by **You and the other analysts**, even if **everyone attempts** to use **"objective" methods** to arrive at these **judgments** (there are **many such methods**, and they **don't always** lead to the **same conclusions**).

Thus the **assessment** of **complicated probabilities** is **inherently subjective** — there are **"judgment calls"** built into **probabilistic** and **statistical analysis**.

"Objectivity" and Subjectivity (continued)

With this in mind **attention** in **all three approaches** should evidently **shift away** from trying to achieve **"objectivity"** toward **two things**:

(1) the **explicit statement** of the **assumptions** and **judgments made** on the way to Your **probability assessments**, so that **other people** may consider their **plausibility**, and

(2) **sensitivity analyses** exploring the **mapping** from **assumptions** to **conclusions**.

(To a **Bayesian**, saying that $P_B(A)$ is **objective** just means that **lots of people** more or less **agree on its value**.)

Suppose that, with **this patient's values** of **relevant demographic variables**, the **prevalence** of HIV **estimated** from the **medical literature**, $P(A) = P(\text{he's HIV-positive})$, in his recognizable subpopulation is about $\frac{1}{100} = \mathbf{0.01}$.

To **improve** this **estimate** by **gathering data specific to this patient**, You decide to **draw some blood** and get a **result** from *ELISA*.

Sequential Learning; Bayes's Theorem

Suppose the **test** comes back **positive** — what's Your **updated** $P(A)$?

Bayesian probability has that **name** because of the **simple updating rule** attributed to **Thomas Bayes** (1763), who was the **first person** to **define conditional probability** and make **calculations** with it:

Bayes's Theorem for propositions:
$$P(A|D) = \frac{P(A)\,P(D|A)}{P(D)\,.} \tag{1}$$

In the **usual application** of this, A is an **unknown quantity** (such as the **truth value** of some **proposition**) and D stands for some **data** relevant to Your **uncertainty** about A:

$$\begin{aligned} P(\text{unknown}|\text{data}) &= \frac{P(\text{unknown})\,P(\text{data}|\text{unknown})}{\text{normalizing constant}} \\ \textbf{posterior} &= c \cdot \textbf{prior} \cdot \textbf{likelihood} \end{aligned} \tag{2}$$

The terms **prior** and **posterior** emphasize the **sequential nature** of the **learning process** — $P(\text{unknown})$ was Your **uncertainty assessment before** the **data** arrived; this is **updated multiplicatively** on the **probability scale** by the **likelihood** $P(\text{data}|\text{unknown})$, and **renormalized**

Bayes's Theorem in Odds Form

so that **total probability** remains **1** — but **in general** the **prior** is a **quantification** of **all information** about the **unknown external** to the **present data set**.

Writing the **Theorem** both for A and (not A) and **combining** gives a (perhaps even **more**) **useful** version: **Bayes's Theorem in Odds Form:**

$$\frac{P(A|\text{data})}{P(\text{not } A|\text{data})} = \left[\frac{P(A)}{P(\text{not } A)}\right] \cdot \left[\frac{P(\text{data}|A)}{P(\text{data}|\text{not } A)}\right]$$

$$\begin{pmatrix}\textbf{posterior}\\ \textbf{odds}\end{pmatrix} = \begin{pmatrix}\textbf{prior}\\ \textbf{odds}\end{pmatrix} \cdot \begin{pmatrix}\textbf{Bayes}\\ \textbf{factor}\end{pmatrix} \tag{3}$$

Another name for the **Bayes factor** is the **likelihood ratio**, since this factor measures the **relative plausibility** of the **data** given A and (not A).

Applying this to the **HIV example** requires **additional information** about *ELISA* obtained by **screening** the **blood** of people with **known HIV status**:

$$\begin{aligned}\textbf{sensitivity} &= P(\textit{ELISA} \text{ positive}|\text{HIV positive}) \quad \text{and} \\ \textbf{specificity} &= P(\textit{ELISA} \text{ negative}|\text{HIV negative})\,.\end{aligned} \tag{4}$$

Sensitivity and Specificity

In practice, in 1985 *ELISA*'s **operating characteristics** were (or at least seemed) **rather good — sensitivity** about **0.95**, **specificity** about **0.98** — so You might well **expect** that $P(\text{this patient HIV positive}|\textit{ELISA}\text{ positive})$ would be **close to 1**.

Here the **updating** produces a **surprising result** (if you've never **seen this sort of thing** before): the **Bayes factor** comes out

$$B = \frac{\text{sensitivity}}{1 - \text{specificity}} = \frac{0.95}{0.02} = 47.5, \tag{5}$$

which **sounds** like **strong evidence** that this patient **is HIV positive**, but the **prior odds** are quite a bit **stronger the other way** ($\frac{P(A)}{1-P(A)} = 99$ to 1 **against** HIV), leading to **posterior odds** of $\frac{99}{47.5} \doteq 2.08$ **against HIV**, i.e., $P(\text{HIV positive}|\text{data}) = \frac{1}{1+\text{odds}} = \frac{95}{293} \doteq \mathbf{0.32}$ (!).

The **reason** for this is that *ELISA* was **designed** to have a **vastly better false negative** rate — $P(\text{HIV positive}|\ \textit{ELISA}\text{ negative}) = \frac{5}{9707} \doteq 0.00052 \doteq 1$ in 1941 — than **false positive** rate — $P(\text{HIV negative}|\ \textit{ELISA}\text{ positive}) = \frac{198}{293} \doteq 0.68 \doteq \mathbf{2\text{ in }3}$.

Inference and Decision-Making

This in turn is **because** *ELISA*'s **developers** judged that it's **far worse to tell somebody who's HIV positive that they're not than the other way around** (reasonable for using *ELISA* for, e.g., **blood bank screening**).

This **false positive rate** would make widespread screening for HIV based only on *ELISA* a **truly bad idea**.

Formalizing the **consequences** of the **two types of error** in **diagnostic screening** would require **quantifying misclassification costs**, which **shifts** the **focus** from (scientific) **inference** (the **acquisition** of **knowledge** for its **own sake**: Is **this patient** really **HIV-positive**?) to **decision-making** (putting that **knowledge** to work to make a **choice**, e.g.: What use of *ELISA* and *Western Blot* would yield the **optimal screening strategy**?).

Axiomatic approaches to **rational decision-making** date back to **Ramsay** (1926), with **von Neumann and Morgenstern** (1944) and **Savage** (1954) also making **major contributions**.

Bayesian Decision Theory

The **ingredients** of a **general decision problem** (e.g., Bernardo and Smith, 1994) **include**

- A set $\{a_i, i \in I\}$ of available **actions**, one of which You will **choose**;
  - For each **action** a_i, a set $\{E_j, j \in J\}$ of **uncertain outcomes** describing **what will happen** if You **choose action** a_i;
- A set $\{c_j, j \in J\}$ of **consequences** corresponding to the **outcomes** $\{E_j, j \in J\}$; and
- A **preference relation** $\preceq$, **expressing Your preferences** between **pairs** of **available actions** ($a_1 \preceq a_2$ means "a_1 is **not preferred** by You to a_2").

Define $a_1 \sim a_2$ ("a_1 and a_2 are **equivalent**" to You) iff $a_1 \preceq a_2$ and $a_2 \preceq a_1$.

This **preference relation** induces a **qualitative ordering** of the **uncertain outcomes** ($E \preceq F$ means "E is not more likely than F"), but within this **framework further assumptions** — the **coherence** axioms — are needed to **ensure** that **Your actions** are **internally consistent**.

Decision-Theory Axioms

Informally (see Bernardo and Smith, 1994, for the **formalism**) these are:

- An **axiom** insisting that You be **willing** to **express preferences** between simple **dichotomized possible actions** ($\{a, \text{not } a\}$);
- A **transitivity axiom** in which (for **all actions** a, a_1, a_2, a_3) $a \leq a$, and if $a_1 \leq a_2$ and $a_2 \leq a_3$ then $a_1 \leq a_3$; and
- An **axiom** based on the **sure-thing principle**: if, in **two situations**, no matter how the **first comes out** the **corresponding outcome** in the **second** is **preferable**, then **You should prefer** the **second situation overall**.

This puts $\leq$ on a **sound footing** for **qualitative uncertainty assessment**, but **does not yet imply** how to **quantify** — it's like being able to **say** that **one thing weighs less than another** but not to say **by how much**.

To go **further** requires a **fourth assumption**, analogous to the **existence** of a **set** of **reference standards** (e.g., an **official kg weight**, **half-kg**, and so on) and the **ability** to make **arbitrarily precise comparisons** with these **standards**:

Utility; Implications

- An **axiom** guaranteeing that for each **outcome** E there **exists** a **standard outcome** S (e.g., **"idealized coin lands heads"**) such that $E \sim S$.

This **framework implies** the **existence** and **uniqueness** of a **(personal) probability** $P_{B:\text{You}}$ (abbreviated P), mapping from **outcomes** E to $[0, 1]$ and **corresponding** to the **judgments** in **Your definition** of $\leq$, and a

utility function U_{You} (abbreviated U; **large values preferred**, without loss of **generality**), mapping from **consequences** c to $\Re$ and **quantifying Your preferences**.

This has all been rather **abstract**; **three concrete results** arising from this **framework** may make its **implications clearer**:

- **Bayes's original definition** of **personal probability** is **helpful** in thinking about **how to quantify uncertainty**.

Supposing that **consequences** are **monetary** (e.g., **US$**), to say that $P_{B:\text{You}}(E) = p$ for some **uncertain outcome** E whose **truth value** will be **known** in the **future** is to say that You're **indifferent** between

Dutch Book

(a) **receiving** $\$(p \cdot m)$ **for sure** (for some **hypothetical** (and **reasonably small**) amount of **money** $\$m$) and (b) **betting** with someone in **such a way** that **You'll get** $\$m$ if E turns out to be **true** and **nothing if not** (You can **use this** to **estimate** $P_{B:\text{You}}(E)$).

- Any **coherent** set of **probability judgments** must satisfy the **standard axioms** and **theorems** of a **finitely additive probability**:

— $0 \leq P(E) \leq 1$ and $P(E^c) = 1 - P(E)$;

— $P(E_1 \text{ or } \ldots \text{ or } E_J) = \sum_{j \in J} P(E_j)$ for any **finite collection** $\{E_j, j \in J\}$ of **disjoint outcomes**;

— $P(E \text{ and } F) = P(E) \cdot P(F)$ for any two **independent outcomes** (informally, E and F are **independent** if Your **uncertainty judgments** involving **one of them** are **unaffected** by **information** about the **other**); and

— **Conditional probability** has a **natural definition** in this **setup**, corresponding to the **updating** of Your **uncertainty** about E in light of F, and with this definition $P(E|F) = \frac{P(E \text{ and } F)}{P(F)}$.

Maximization of Expected Utility

Otherwise (de Finetti, 1964) someone **betting with You** on the **basis** of **Your probability judgments** can **make Dutch book against you**, i.e., get You to **agree** to a **series of bets** that are **guaranteed** to **lose You money**.

Thus **coherent Bayesian probability obeys the same laws** as with the **classical** and **frequentist approaches** (apart from a **technical issue** about **finite** versus **countable additivity**).

Nothing so far has **said clearly what choice to make** in a **decision problem** if You wish to **avoid incoherence**.

If the **outcomes were certain** You'd evidently **choose the action** that **maximizes Your utility function**, but **since they're not** the **best action** must involve **weighing both Your probabilities** for the **uncertain outcomes** and the **utilities** You place on their **consequences**.

It's a **direct implication** of the **framework here** that the **form** this **weighing** should take is **simple** and **clear**:

HIV Case Study

Maximization of Expected Utility (MEU)

Given Your **probability** and **utility judgments**, Your **decision-making** is **coherent** iff for **each action** a_i, with **associated uncertain outcomes** $\{E_j, j \in J\}$ and **consequences** $\{c_j, j \in J\}$, You **compute** the **expected utility** $\text{EU}_i = \sum_{j \in J} U(c_j)P(E_j)$ and **choose** the **action** that **maximizes** $\{\text{EU}_i, i \in I\}$.

Example: HIV screening. As a **simplified version** of this **problem** consider **choosing** between **two actions**:

- a_1: Obtain *ELISA* **results** at a **cost** of $c_1 = \$20$; if **positive**, conclude this patient is **HIV+**, if **negative**, conclude **HIV−**.

- a_2: Same as a_1 except if *ELISA* comes out **positive**, obtain *Western Blot (WB)* **results** at an **additional cost** of $c_2 = \$100$; if *WB* is **positive** conclude **HIV+**, if **negative** conclude **HIV−**.

With action a_1 the **probabilities**, **uncertain outcomes**, and **utilities** are as follows:

HIV Case Study (continued)

Probability	True HIV Status	*ELISA* Status	Utility
.0095	+	+	$-c_1$
.0005	+	−	$-c_1 - L_{\text{I}}$
.0198	−	+	$-c_1 - L_{\text{II}}$
.9702	−	−	$-c_1$

Here L_{I} and L_{II} are the **false negative** (**false positive**) monetary losses suffered by this patient if he really is HIV+ (HIV–) but *ELISA* says he is HIV– (HIV+).

The **expected utility** with **action** a_1 is thus

$$\begin{aligned} \text{EU}_1 &= .0095(-c_1) + .0005(-c_1 - L_{\text{I}}) + \ldots + .9702(-c_1) \\ &= -(c_1 + .0005L_{\text{I}} + .0198L_{\text{II}}) \ . \end{aligned} \tag{6}$$

The **corresponding table** for **action** a_2 is:

HIV Case Study (continued)

Probability	True HIV Status	*ELISA* Status	*WB* Status	Utility
.00945	+	+	+	$-c_1 - c_2$
.00005	+	+	−	$-c_1 - c_2 - L_{\text{I}}$
.00004	+	−	+	$-c_1 - L_{\text{I}}$
.00046	+	−	−	$-c_1 - L_{\text{I}}$
.00010	−	+	+	$-c_1 - c_2 - L_{\text{II}}$
.01970	−	+	−	$-c_1 - c_2$
.00095	−	−	+	$-c_1$
.96925	−	−	−	$-c_1$

These **probabilities arise** from *WB*'s **design** (the **goal** was to have **about the same false negative rate** as *ELISA* and a **much lower false positive rate** (about 0.1), leading to a **slightly worse sensitivity** (0.949) but **much improved specificity** (0.999)).

The **expected utility** with **action** a_2 comes out

$$\begin{aligned} \text{EU}_2 &= .00945(-c_1 - c_2) + \ldots + .9604(-c_1) \\ &= -(c_1 + .0293c_2 + .00055L_{\text{I}} + .0001L_{\text{II}}) \; . \end{aligned} \tag{7}$$

By **MEU** You should **prefer** a_2 to a_1 iff $\text{EU}_2 > \text{EU}_1$, i.e., iff

HIV Case Study

$$\boxed{.0197L_{\text{II}} - .00005L_{\text{I}} - .0293c_2 > 0\ .}$$

Thus a_2 becomes **more desirable** as the **loss** suffered with a **false positive (negative) increases (decreases)**, and **less desirable** as *WB*'s **cost increases**, all of which **makes good sense**.

It's **interesting** to note that with a **modest value** for L_{II} (e.g., **$1,000**), the **monetary advantage** from taking **action** a_2 is **quite small**, even with a **realistically huge value** for L_{I} (e.g., **$100,000**, which leads to an **edge** for a_2 of **only about $12**).

This is due to the **extremely low false negative rate** for **both tests** — L_{I} would have to be **over $335,000** for a_1 to **dominate**!

Overall conclusion: for **realistic** values of L_{I} and L_{II} the **adaptive** strategy a_2 is **better**.

We'll see **many more examples** of **maximizing expected utility** later in this **short course**.

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