Physician tips on how to talk to patients about vaccines

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Featured topic and speakers

In today’s COVID-19 Update, get information on how to talk about vaccines with patients and address vaccine hesitancy, as well as why putting "inoculation" in the search bar is more advantageous than "vaccination."

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Speakers

- Marie Brown, MD, professor, Rush University and director, practice redesign, AMA
- Constance A. Benson, MD, professor of medicine & global public health, UC San Diego

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today, we're going to be sharing tips for how to talk about vaccines with patients and how to address vaccine hesitancy. I'm joined today by Dr. Marie Brown, director of Practice Redesign at the AMA and professor of internal medicine at Rush University in Chicago. Dr. Brown has over 30 years of experience caring for patients as an internal medicine specialist, and Dr. Constance Benson, professor of medicine and global public health at the University of California in San Diego. I'm Todd Unger, AMA's chief experience officer in Chicago.

Unger: Dr. Brown, let's start with you. You recently hosted a webinar called Vaccinations: A Roadmap for Success, that address the important conversations that physicians need to have with patients about vaccines. Why do we see any hesitancy in getting vaccines when they've proven over and over again to prevent disease?

Dr. Brown: That's an excellent question, and thank you for inviting us. For most of us on the call
today, it is really perplexing and even frustrating, because most of us had either already had our vaccine or eagerly awaiting to get scheduled for it, so it's easy to roll our eyes, throw up our hands and just hope that science will prevail, but many, many patients really are just trying to do the right thing. They hear so many different stories out there that they don't know what to think, and that's where the physician and health care workers are so important because we are the most trusted resource for information about the vaccine.

Unger: Yeah. You mentioned there is a lot of misinformation, I think. Would you say it's kind of unprecedented in terms of social media response that we're seeing right now and the amount of misinformation?

Dr. Brown: Well, it's very interesting because vaccine hesitancy in the anti-vaccine movement can really be traced back 200 years to 1840, when the British Vaccination Act mandated smallpox vaccine, and actually, the phrase, "conscientious objector" came from people who had religious concerns and objected to receiving the vaccine. Then, fast-forward, and only as recently as 1998, Dr. Andrew Wakefield in the UK falsely linked vaccination to autism, which has been proven clearly to be not associated at all. Then, polio also, which could have been eradicated from this planet, of similarly religious leaders in the Middle East, suggesting misinforming people that the polio vaccine was laced with estrogen and could cause sterility in their male children, so it's been around for a long time. Because of social media, it is much more influential now.

Unger: I saw that back in the day, it even took Elvis to help overcome vaccine hesitancy in the days of polio. Dr. Benson, speaking of history, you are an expert on HIV and AIDS. When that first emerged, it also caused a lot of fear and confusion. Are there any lessons learned that can help physicians to talk to patients about COVID-19?

Dr. Benson: Well, I think when I think back about the early days of the HIV pandemic, there are a lot of corollaries to what we're experiencing right now, and I think the first is that an organized governmental response to a major global pandemic is something that's really necessary, and unfortunately, I think we didn't learn that from HIV and AIDS. We repeated that mistake in our current pandemic, but secondly, I think with any new and emerging infectious disease, there's always fear. There's always stigma associated with the people who experienced that disease. I think we've learned a little bit from HIV and AIDS, although fear and stigma still drives a lot of what people do and think about COVID right now. We are more inclined, I think, in this era to embrace those who are ill with COVID and not push them away or stigmatize them in the same way that we did with HIV and AIDS.

Dr. Benson: Then the third lesson, I think is a very important one, and that's to recognize that with any new disease like COVID-19, you have changing information constantly bombarding us, sometimes misinformation, as you talked about and Dr. Brown talked about, but sometimes just with a new and emerging infection, we don't know everything we need to know at the beginning. We
oftentimes are forced into giving recommendations and advice based on lack of data about how things should be evolving, and once we get new information, our recommendations and guidance changes. I think one lesson to be learned from that experience with HIV is that changing your recommendation doesn't mean you were wrong in the first place. It just means that you didn't have all of the information you needed when you initially made that recommendation, and it's a good thing to change the recommendation when you have new information related to the disease process.

Unger: Yeah. That's a really important point. I'm not sure, people are used to seeing medicine learning in real time like this and getting used to making adjustments, which is just part of the way things work. How do physicians take something that's so complicated as infectious disease and immunity, and simplify it in ways that patients can understand? Dr. Benson, will you start?

Dr. Benson: Sure. I think Dr. Brown has very good tools for doing that, as she illustrated on her webinar, but she and I both use a lot of the same tools. We use analogies. We often will use pictures because immunity and infection are difficult concepts to get across to some people, average people that we deal with in our health care settings. I will sometimes use an analogy like what we used with HIV, taking it from your earlier question.

When we talk to people about a CD4 cell count, that was something that was a new concept. It's part of the immune system, and the way I illustrated how those cells work in your body is to talk about the CD4 T helper cell as the conductor of an orchestra. That particular cell governs how all of the other parts of the immune system work when there's a new invader that gets into your body, and the first line of defense is that CD4 helper cell, and the CD4 helper cell then points to different parts of the orchestra to get them to start playing along, and pretty soon, you have a symphony that draws all the parts together and makes your immune system work. If that orchestra and if that conductor is not working properly or is not there, then all the disparate parts of the orchestra start playing at once or playing too loud, and you just have noise. That to me is one of the analogies that I used for the HIV/AIDS epidemic.

We have a similar construct in talking about COVID-19 immunity, in that antibodies and T cells are both important components of your host defense, your immune system. When you encounter any new invader, they have to marshal all of the parts of the orchestra and get them playing together so that you have a symphony that works together to drown out what's happening with that virus.

Unger: Is that, I think if I get the pronunciation right, a cytokine storm? Does that sound really bad in that analogy?

Dr. Benson: Cytokine storm is something that happens when the orchestra is ...

Unger: Cytokine.
Dr. Benson: ... when there are different elements of the orchestra that are playing too loudly and drowning out the good parts of the orchestra or the other parts of the orchestra that are necessary for your immune response, and so cytokine storm occurs with COVID-19 when your immune system is overreacting, meaning the conductor is making too much out of the horn components and making loud noise, and overwhelming the rest of the orchestra, so the symphony can't play.

Unger: See, I understand that now. Thank you for that analogy. Dr. Brown, do you have any perspective on that question about how you simplify these concepts for people to really understand?

Dr. Brown: No. I think Dr. Benson had a really good metaphor there, but I think before you even can have that conversation with the patient, you need to respect their perspective, and you're not even going to calm your own emotion and perhaps frustration, that they've declined the vaccine and don't want to talk about it, so we need to say, "Could I ask you, why are you declining it? What are you thinking?" Often, they're frustrated or embarrassed to say what they're actually thinking, and this goes to your team as well. Instead of saying, "Well, why are you declining it?," which is sort of judgmental, because they know the perspective you have, and it puts them in an awkward situation, so especially with my team, my health care team, I would say, "What have you heard in your community?"

They may have the thought, but it's just more comfortable for them to say, "Well, I've heard that the vaccine can give you the disease. I've heard that if everybody else gets it, I won't need it. I've heard that this was all made up," so over 70% of the U.S. population has heard that this was a plandemic, that this was a designed program by the elite who are pro-vaccine, and it is orchestrated, to change the metaphor, Dr. Benson, and a third of those people believe that this was not a natural event.

Unger: I just want to probe a little bit more on that because that's something that I think about. I'm not a physician. I deal a lot in marketing, and this is a marketing issue to some extent, so you talked about those kinds of different segments, and you have people out there that are believers, and they just want to know kind of, "Where and when do I get this?" You have kind of people in the middle that are hesitant for one reason or another, and then maybe on the far end of that, that you have people where some of the rationales would not be science-based, that are based on misinformation, real structural issues. How in your mind, Dr. Brown, first, do you think about these different segments and how do you approach each one differently?

Dr. Brown: That's a great question. After 30 years of recommending vaccinations, I've really stepped back and really learned a lot from my patient's perspective, but I grouped them into three groups, the vast majority, 70, 90% in Europe and the United States are pro-vaccine. This is wonderful. We've saved millions of lives. It's the best thing that's ever happened to this planet. It only compares to clean water as far as the health of the population of earth.

Then, the very extreme, which is a relatively small number, however, their influence is greater than
that small number would you’d expect, and in the middle are the vaccine hesitant. Generally speaking, we’re never going to change the minds of the anti-vaccine believers. They are based on non-science and often conspiracy theories, and in fact, don’t even believe in the concept of immunization. No conversation in the world is going to change their mind. However, the vast majority are busy people, busy mom and dads, people trying to just get through the day, and how difficult that is right now.

**Dr. Brown:** They want to do the right thing, but on social media or in their communities, they're hearing so many anti-vaccine theories, that it gives them pause, and if you hear it often enough, you begin to think it's true. We, as science-based, and everybody on this call and all of us, whether you're a psychiatrist, a surgeon, work at the AMA or a medical assistant, a nurse, a dentist, we all have to be very clear that vaccines are helpful. That's the only way we're going to get this pandemic under control, let alone behind us, and saying nothing is saying something. 85% of the patient of the U.S. population believes and trusts their health care provider or their physician. We are the most trusted resource, so we have to say the same, have the same message that these vaccines are safe.

We all have to have the same message that these vaccines are safe, and it's really the only way to get back to normalcy, to be with our family, our friends, to get back to work, to get back to school, and some sort of normalcy and put this pandemic behind us.

**Unger:** That's such an important message. Unfortunately, what are seeing some of the greatest vaccine hesitancy in populations, hardest hit by COVID-19. Dr. Brown, why is this the case, and how do physicians tailor their messages so it reaches these groups?

**Dr. Brown:** Well, a lot of it is we really need to increase our own knowledge. Even before social media, especially in the African-American population, there's that history of Tuskegee. This was funded by the CDC. It started in 1932, but continued long after penicillin was available and recommended for treatment of syphilis. These were farmers, and in 1942, they were denied the treatment for syphilis of penicillin.

Sadly, that study continued for another 30 years, and these families, can you imagine, these farmers were denied that treatment. The underlying mistrust of the government is there, and patients may not share that with you, but they know what happened then, and we need to understand their perspective. We cannot just get frustrated with them and say, "Oh, they're not trusting me. They should trust me. I know better."

We really need to understand their perspective and respect it in order to meet them and try to build that trust again, recognizing what has happened in the past so that we can go forward, and I know Dr. Benson in Southern California has some thoughts about the Latina community. Dr. Benson, you were telling me about that.
Dr. Benson: Yeah. Yeah. Our experience in Southern California, especially near the Mexico border, where I live and work, is largely the experience of dealing with the mistrust of the health care system on the part of the Latinx community. That’s not a homogeneous community, so it oftentimes is somewhat difficult to traverse for health care professionals, but one of the principle features that are dealing with our community has that’s shared with the African-American community is that sense of mistrust of the government, less linked to some of the past history of government experimentation and more linked to the current history of government dealing with immigration, and border control, and border protection, and a lot of our community doesn’t even access the health care system because they’re afraid. They’re afraid to go and see a physician if they’re having symptoms of COVID.

Dr. Benson: They know that it exists in the community, but what they hear and deal with has to do with what they see on television or what they hear from their friends and families. Just as you've heard in a lot of media, our community is a representative of a lot of the Latinx community. We have very large multi-generational families living together. They're often working in essential jobs, where they can't stay home and work on Zoom and social distance, so they must go into the workplace. They're exposed in the workplace to other people with COVID and have very little resources and recourse to deal with what's happening in their own communities, so the idea that they would access the health care system to deal with that only comes when they're nearly, I hate to use the phrase, but on death's doorstep, because that's when we see them in the hospital, and we don't see them early in the course of their disease, so we never had that opportunity to talk to them about social distancing, about mask wearing, about some of the things that we use to protect themselves, even in their own homes.

I think that's a different part of the pandemic that other places that have much larger African-American communities deal with, but I think the point here is that we all have underrepresented populations or marginalized communities that are part of the conversation about COVID, they're part of the conversation about immunizations, and if they don't ever even access the health care system due to that mistrust, we can't even start that conversation about prevention and about immunization.

Unger: Absolutely. Well, one of the other things that we're seeing over the course of this early phase, especially, it's not just vaccine hesitancy among perspective, among patients, we're seeing that among health care workers too. Dr. Brown, how do you work with or deal with that kind of hesitancy among health care workers?

Dr. Brown: Great question, Todd, and that is really one of the most surprising things in the surveys, that 29, 30% of health care workers are reluctant to get the vaccine, and their same concerns mirror the concerns throughout the country. In this day and age, there is different concerns depending on your political party, so the country is split between their attitude about whether taking the vaccine is a personal choice or responsibility to society, and if you only have one message, then it's going to be the wrong message for half your patients, unless you know the attitudes of the patients coming in.
Asking a patient what they think about, whether it's a personal choice, and then agreeing that, yes, of course, it's a personal choice, and we have to respect that, those same people also value and know that they are concerned about the people at home. Instead of saying, well, and explaining herd immunity, pivot and talk to them about ... Ask them, "Who's at home? Do you have a grandmother at home?"

"Do you have a grandfather at home?," and, "You need to take the vaccine to protect them." That is going to be a much more effective, tailored message.

Unger: Absolutely. Dr. Benson, we briefly touched on this before, but obviously, there's a real fear about side effects, and we've heard various things about it, we've heard to expect some around the second dose. How should physicians communicate to their patients the realities without scaring them?

Dr. Benson: Well, I think many patients who already have been immunized or vaccinated against other diseases are very familiar with that discussion, about potential side effects of a vaccine. The vaccines that we're administering now and that we have being tested in clinical trials are not that very much different from other vaccines that people are used to getting, and so the way I start the conversation really has to do with, "How did you feel after your last influenza vaccination?," or, "Did you have problems with a previous vaccination?," and talk a little bit about that, and then move into the conversation about, "This vaccine is not very much different. You're likely to have modest pain at the site where you get your injection. You might have flu-like symptoms for a couple of days thereafter. Most of these are short-lived and don't cause problems, and ultimately, they resolve on their own without any further intervention."

Dr. Benson: Again, I think Dr. Brown made a very good point that you personalize that discussion. Ask them about previous reactions. Ask them what they think about, whether they experienced side effects from another vaccine before and what those side effects were like, and then build on that conversation to talk about side effects related to this one.

Dr. Brown: I think that's a very important point. When I talk to patients, I will generally hope for the best, but plan for the worst, because with that second dose, if they have a lot of symptoms and they don't expect them, then what are they going to tell their community and their coworkers, right? They're going to say, "Oh, I got so sick." Right? "I got COVID from that," so I say, "You're probably going to feel pretty bad."

"You might feel pretty lousy for 24 hours. Hopefully not, but some people do, and that just means your immune system is revved up and ready to work. That's a good thing." In fact, I have colleagues who went back to work after they got their second dose, and the physicians that had a more robust myalgias and some fatigue, people were jealous of them. They're like, "Oh, you've got a really good immune response."
Now, that's amongst physicians, but that's because we're so science-based, but our patients don't understand that, and that person who gets that reaction and wasn't prepared for it could tell five more people, and they tell five more people, and that promotes that hesitancy that we have to be prepared to counter.

Unger: Well, Dr. Brown, I know there's a lot more to talk about here that we're not able to cover that was covered in your webinar. What do you recommend to physicians in terms of gaining access to your webinar and other resources out there about the COVID-19 vaccine?

Dr. Brown: Well, cdc.gov, immunize.org and the AMA has a COVID resource page and a lot of webinars, including this one, this podcast, and a lengthier webinar on addressing, and actually script, scripts for physicians to hand their staff so that when the patients come in, the staff is giving the same message that the physician is. Just go to AMA website COVID resource page.

Unger: You had some interesting advice, and obviously, a place that people always start is they go onto Google and they type in a search term, a nuance there. What do you suggest that they search for?

Dr. Brown: Well, it's interesting. You don't want to search or tell your patients to search for the term, vaccination, because you'll get more anti-vaccine websites, because anti-vaxxers don't believe in the concept of immunization, so you want to Google immunization, but if you search for emerging topics, webinar or AMA vaccination, you should see some of these wonderful resources that are out there.

Unger: That's excellent. Well, thank you so much, Dr. Brown, Dr. Benson for being here. Again, as Dr. Brown said, you can check out the AMA site in our COVID resource center at ama-assn.org/COVID-19 for more information. Thanks for joining us here today. We'll be back tomorrow with another COVID-19 update segment.

Unger: Thanks for joining us. Please take care.

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