PERSPECTIVES IN HOSPITAL MEDICINE

When the messenger affects the message: Trustworthiness in the context of COVID vaccination

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On a recent Sunday morning on one of our hospital medicine services, a supervising physician inquired about a patient's coronavirus vaccination status. On admission, the patient was unvaccinated and not planning to become so. He responded, "Well (pointing to the intern physician), I've been knowing this doctor for a couple of days now, and she seems to think it's a good idea, and I trust what she's been doing for me." Prior to discharge, he received his first dose of an mRNA vaccine and an appointment card for dose #2. Despite having undoubtedly received countless messages regarding the urgency and efficacy of getting vaccinated, he had not. What had the physician done to affect his decision? A deconstruction of factors influencing vaccine behaviors and trust formation may help clarify this interaction. Clinicians, in their roles as caregivers, have a unique opportunity to act as trusted messengers within public health efforts. We contend that this can be accomplished through better understanding the foundational elements of trust-building and, when presumptive trust in clinicians is insufficient, by transitioning trust-building from its often-subconscious process into a deliberate one.

For many, the decision to get vaccinated is not an easy one. At the individual level, it can be viewed through the framework of the Health Belief Model, in which the likelihood of vaccination depends on a balance of perceived risks (e.g., of vaccination and coronavirus infection, social consequences), perceived benefits of the vaccine, and practical barriers to receiving the vaccine.[1] The vaccination campaign in the United States has been reasonably effective in reducing practical barriers to vaccine delivery. Federal actions have mitigated many financial obstacles. With notable exceptions (e.g., such as those contributing to vaccination disparities),[2,3] vaccination sites are now dispersed among many of our communities, including at grocery stores, sporting events, and through mobile units. While there is still a population of eligible individuals who remain unvaccinated because they simply "haven't gotten around to it," there are many who perceive vaccination risks to outweigh the benefits. Ultimately, this risk-benefit analysis is heavily dependent on the information sources that patients trust.

The Social Ecological Model (SEM) provides a lens through which to view the myriad individual and contextual factors impacting trust in messaging and messengers within the context of vaccine decision-making.[4] In this model, *individuals* have past experiences that impact their disposition to trust, such as adverse childhood events, positive experiences in the healthcare system, or having experienced discrimination or other negative outcomes within that system. Trust can be further shaped by pre-existing health attitudes and beliefs. Beyond this baseline state, trust is influenced by a delicate interplay of *interpersonal* factors. Examples include friends, family, social media, and social norms, which are then balanced against the broader *community*, *institutional* and *societal* constructs representing healthcare and public health systems, community social dynamics, local and national government agencies or groups, political climate, and public policies (e.g., mask or vaccine mandates). Examples of key potential influences within the SEM framework as applied to the current pandemic are detailed in Figure 1. Importantly, these influences are not static. Peer groups change, trusted messengers gain or lose credibility, conspiracy theories fall flat, and perceptions shift about institutional or public policies, especially given the dynamic nature of the pandemic and its impact on communities.

The trust at the foundation of clinician-patient relationships is often navigated by both parties subconsciously. By virtue of training, experience, and societal norms, clinicians are often afforded high levels of presumptive trust by patients. We recommend therapies, perform procedures, help navigate end-of-life decisions,
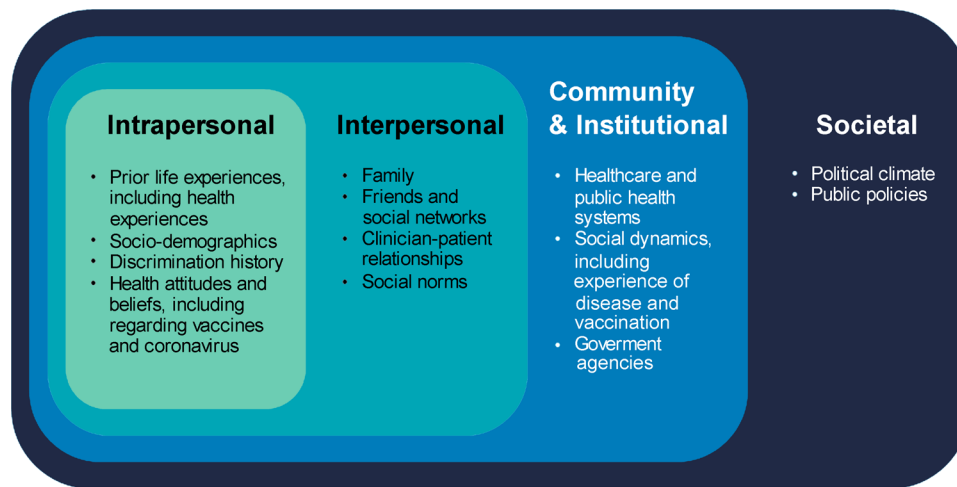
FIGURE 1 Factors influencing trust in messages and messengers, within the context of vaccination decisions, according to the Social Ecological Model[5–8]

and are invited into intimate aspects of others' lives; all despite the many missteps attributed to our professions such as conflicts of interest, tolerance of institutional discrimination, and medical errors. However, in instances when presumptive trust is lacking, clinicians have a unique opportunity to engage deliberately in trust-building. To do so, a deeper understanding of trustworthiness and entrustment is needed. The literature of medicine, psychology, sociology, and philosophy provides insights into how clinicians might approach this.[9–12]

1. Authenticity: We must be authentic persons in our interactions with patients. Our patients routinely make this determination about us. If we are perceived as artificial or playing a role, we are not likely to be viewed as trustworthy.[13] In conversations about vaccination, we should willingly acknowledge that our dialogue is occurring within a broader societal context marked by politicization, evolving scientific knowledge, rapidly changing and sometimes seemingly contradictory public health recommendations, apprehension, and even fear. In some cases, naming these emotions and acknowledging our own reservations may help demonstrate our authenticity.

2. Empathy: An essential aspect of our professional roles is that we empathize with the suffering and circumstance of our patients.[14,15] We must also understand and empathize with concerns and confusion related to vaccine decisions, recognizing that a variety of factors, aside from simply our clinician-patient relationships, influence individuals' choices. Doing so allows us to approach such conversations openly and accept that patients may ultimately decide, in any given interaction, not to vaccinate. This approach is grounded in respect for persons and their autonomy and allows us to approach conversations with limited judgment or bias to the extent possible.

3. Transparency: Transparency is not simply the full and ready availability of information; it can also be an active process of creating shared understanding about information through dialogue. It is a necessary condition for trust to develop, and effective communication is at the heart of this.[14] We must listen with open, curious minds and commit the requisite time to fully understand our patients' concerns. Only then can we truly understand their values, whether and how vaccination aligns with their goals, and identify points of ambivalence or decisional conflict. We must also be clear about our recommendations and reasoning and remain aware of our verbal and non-verbal cues and personal biases.[15] When feasible, we must repeat these conversations to share new information, reflect on prior discussions, and ensure that we have a shared understanding of one another, even in the absence of agreement.

4. Shared understanding and goals: Communicating our individual goals to foster mutual understanding and identifying or creating shared goals is paramount in this process.[14] What are our patients trusting us to do? Have we listened well enough to understand their goals and whether our recommendations align with them? Do they understand our motivations, and do they believe that our goals are to care for them and to help them reach their goals?

5. Competence and accountability: An underappreciated factor in trust building is how it can be impacted by perceptions of competence and accountability.[14] Disclosing medication errors or remembering to double-back in the afternoons to follow up on questions may seem mundane responsibilities but can profoundly reinforce a message that we are authentic, reliable advocates for our patients. We must do the things we are entrusted to do and recognize the effect of not doing them.

Trust is fragile. It has boundaries. It may be difficult to earn, easy to lose, and even more difficult to re-earn. There is an implicit vulnerability that accompanies the entrustment of others—if a behavior or outcome was assured, trust would be unnecessary. Explicitly

discussing trust with patients is sometimes necessary, especially when its absence undermines our ability to provide effective care, and in motivating behaviors that are ultimately aligned with patients' goals. Having these conversations may also help us uncover prior experiences or factors driving our patients' decision-making, which may be necessary for us to address if we are to assist them in overcoming ambivalence.

Returning to our patient—the initial challenge was substantial. Amid a pandemic that, in late 2021, had claimed nearly 800,000 lives in the United States, and despite his own co-morbidities, the patient arrived at the encounter unvaccinated and unconvinced. So what changed during his short hospitalization? His physician arrived early each morning; a sacrifice made by trainees that patients notice. She carefully listened to the lungs and inspected jugular venous pressure. She doubled back in the afternoon for conversation and called family members on his behalf. When she did not know an answer, she said "I don't know, but I'll find out." She communicated risks and benefits, empathically and honestly. She provided irrefutable evidence that she cared about him. And as he put it—"...I trust what she's been doing for me." Thus, her recommendation about vaccination was received within that context—that she was on his side.

Trust has long been appreciated as central to clinician–patient relationships but is not always guaranteed to us, nor is it always initially sufficient to motivate health-related decisions. In such scenarios, clinicians may build trust with patients by transforming the often-subconscious process of entrustment into a conscious one. Entrustment requires trustworthiness, which is demonstrated by authenticity and accountability, by communication that is grounded in transparency and empathy and is fostered by a mutual understanding of individuals' goals and ideally the identification of shared ones. By doing so, clinicians have a unique opportunity to act as trusted messengers who are crucial to public health efforts, including the urgent need to vaccinate eligible individuals against coronavirus infection.

CONFLICT OF INTEREST

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