Empathy for the Unvaccinated

Dear Editor:

When Dr Ehlenbach shared the news of his father's diagnosis of advanced lung cancer with colleagues, he was frequently asked by these physicians if his father had been a smoker. This question reveals an implicit desire to separate the complicit from the innocent, to fully inform their reaction to the news. Regardless, it is sad that his father was sick and that he died, full stop. Blaming patients for their health problems is a practice that predates scientific medicine, but it seems to have become worse over time. We invoke patients' failure to control diabetes as an explanation for limb loss, lack of discipline as the etiology of obesity, and "medication noncompliance" as the cause of runaway hypertension. Improving health through behavioral modification does not require vilification of patients. But our professions' bad habits threaten to destroy expressions of empathy required for a therapeutic relationship.

Nowhere is this more seditious or prevalent than for our patients with serious illness from COVID-19. The vast majority of patients with COVID currently filling intensive care units in Wisconsin have not received a COVID vaccine, and most of them would not be severely ill had they done so. Tens of thousands of Americans will die because they did not get vaccinated. For an already exhausted workforce, the notion that we could feel less exhausted, safer, and less burned out if people would simply take a free, safe, and highly effective vaccination is as straightforward as it is maddening that so many have not done so. The light at the end of the tunnel has dimmed. It is hard to watch people die from preventable illness. But this is what we do and have always done. It is challenging to care for people whose illness may harm you, yet this is also part of the job – consider tuberculosis, hepatitis C, and HIV. In return for our care, we receive relatively high pay and high status. We are not qualified to be judge and jury. In making these judgements we are likely to make mistakes.

We are desperately in need of a better narrative. Shifting narratives to support empathy can improve care as it has in substance use disorder. When we moved from considering addiction as a moral failing to conceptualizing it as a disease, it fundamentally altered our approach. Shaming our patients for failure to vaccinate, or routinely expressing anger to colleagues that these patients are sick because they are dumb, simply inflames the toxic divisions that got them to this place. To start, we need a different target for our well-justified anger. So we should focus our anger on those who misled them. Elected leaders and media personalities who spread misinformation and social media platforms like Facebook that amplify it have led our patients to make choices that are harming them and those around them. Next, we need to reframe our feelings about critically ill adult patients with COVID. It is tragic and it is exhausting, and we should acknowledge this. A better narrative is that we are sad that our patients succumbed to lies spread by people they trusted. We are flummoxed that they trusted them more than they trusted us. We will do better to be trustworthy, but for now we will fight their illness with them.

People will always be sick, humans will always make bad choices, and we will always be here to take care of them. It's time to have more empathy for the unvaccinated.

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Racial and Ethnic Differences in Zoster Vaccine Uptake: A Cross-Sectional Study in a Veterans Health Administration Primary Care Clinic

Dear Editor:

Zoster vaccine uptake has been disappointing (34.5% of the target population) and marred by racial and ethnic disparities.[1,2] However, studies of uptake generally have limitations. Most are survey-based (and subject to self-report bias) and based largely on the discontinued live vaccine (not the currently available recombinant vaccine).[1,3] Furthermore, much of recent literature describes the situation 3 years ago when the recombinant vaccine was in shortage.[1]

These limitations raise a question: Do these racial and ethnic disparities persist? Insight into that question may be gleaned from a quality improvement project that we initiated to improve zoster vaccine uptake. Our baseline findings overcome those limitations. Our findings are current, record-based, and reflect the recombinant vaccine. Our findings are from a Veterans Health Administration clinic (where insurance and access are not barriers) and may shed light on the question of persistence of disparities, even when those barriers are absent.[4]

We queried the records of the Omaha primary care clinic of the Veterans Health Administration Nebraska-Western Iowa Health Care System for receipt of recombinant zoster vaccine since October 1, 2017. We included patients at least 50 years old on October 1, 2017 (close to the recombinant vaccine approval date) seen in the clinic October 1, 2020-July 5, 2021.

Our population of 10,323 was predominantly male (93.8%); 81.2% were non-Hispanic White, 10.7% were non-Hispanic Black, and 1.5% were Hispanic White. The prevalence of complete vaccination (2 doses) was 39.8% (females 34.7%, males 40.1%). Complete vaccination was 43.3% in non-Hispanic White patients, 33.8% in Hispanic White patients, and 24.9% in non-Hispanic Black patients. Receipt of at least 1 COVID-19 vaccine dose was 80.1%, 78.2%, and 82.2%, respectively.

A 39.8% prevalence of complete vaccination was higher than generally reported for zoster vaccine uptake.[1,2] Conceivably, this could reflect our study population: individuals seen in a clinic with vaccine reminders, standing vaccine orders, onsite vaccine, and no charge for vaccine. [4,5] Racial and ethnic disparities are consistent with most, but not all, of the literature.[1,2]

The contrast between zoster vaccine disparities and their absence with COVID-19 vaccine (for which awareness was extraordinarily high) supports the hypothesis that zoster vaccine disparities arise from disparities in awareness.[2]

Our baseline data confirm the appropriateness of our choice of zoster vaccine uptake as a quality improvement project, showing an opportunity for improving uptake and an opportunity to address factors other than insurance and access that account for racial and ethnic disparities.

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