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Geri Amori, PhD, DFASHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I am joined by Michelle Mello, JD, PhD, a health law scholar at Stanford; John Robert Bautista, RN, MPH, PhD, a postdoctoral teaching fellow at the University of Texas, Austin focusing on health misinformation; and Brian Southwell, PhD, who is a scientist focusing on science misinformation and the public sphere at RTI International. Welcome to our speakers, and welcome to you.

Today, we're talking about methods healthcare clinicians can use to manage patient care when misinformation is driving patient decisions. So, Michelle, let's start with you. Is there a risk for parents who make decisions for their children based upon misinformation? Like, how should healthcare providers determine when Child Protective Services should be called or when parental rights, even if not helpful, are just misguided?

Michelle Mello, JD, PhD: Of course, there's medical risk when parents forego safe and effective preventive care and treatment for their children due to misinformation. I think that you may also be wondering about whether there's a legal risk. Specifically, you know, whether a physician ought to think about involving CPS—Child Protective Services—that's a really tricky question, especially in an age where we are more attuned to inequities in how social systems operate. We have to acknowledge that CPS is one of those institutions that is known to disproportionately go after parents in minoritized populations. And, you know, just like calling the police for minoritized populations can lead to a cascade of very, very serious consequences that can happen here, as well, you know, with the result that the child is much worse off than before.

So, I have a lot of hesitancy around the idea that CPS has a role to play in combatting medical information. You know, from a legal perspective, providers have long had to deal with questions about what to do when they suspect child abuse and neglect. They are mandated reporters of that under state law. And so they're accustomed to having to make tough calls when they suspect neglect is going on. And all of those usual standards of care and legal standards for defining what constitutes neglect apply here, and in some sense, it's just a new wrinkle, but it's an old issue. But states certainly define medical neglect as a type of neglect. The specific standard varies from state to state, and some states require that parents have behaved, you know, unreasonably or failed to exercise some minimal degree of care.

And there's lots of legal argumentation, both in scholarship and in the courts, that foregoing vaccines, in particular, can constitute medical neglect. Sometimes it comes up when parents are fighting about child custody. In my research, I found there was at least 7 courts that have found that a nonreligious refusal of vaccination can constitute neglect. But again, I wouldn't really recommend widening the social net to involve CPS in cases of vaccine refusal unless it's a situation where, you know, serious harm really is quite threatened for the child, you know, a new pandemic of a very virulent pathogen perhaps.

Now, failing to seek treatment for a child who is seriously ill—with COVID or some other illness—that's a different story. You know, there you have clear endangerment, and if that's

spurred by misinformation, that has to be addressed first with the family and then, perhaps, with the authorities. But I'll just close by noting that the American Academy of Pediatrics, too, does not support stringently applying these medical neglect laws or standards when kids don't get recommended vaccines. And part of the reason is that, you know, once you press that nuclear button, your relationship with the family is forever blown. Pediatricians hope that, with trust and time, they can counsel families to reject misinformation and get their children vaccinated.

Amori: Good point—that's a really good point, that's a really good point. So, Brian, an approach centered on simply providing evidence-based health messages or broadly debunking misinformation isn't going to change people's behaviors. That doesn't work. Can you help us understand why it's so difficult, once someone has bought into this, to shift their behavior? What could work?

Brian Southwell, PhD: Yeah. So, you know, Geri, there's really sort of two different streams of thought that your question, you know, provokes. You know, one is this notion that we should be careful and avoid trying to correct misinformation or debunk misinformation. Sometimes people will worry about the so-called backfire effect, you know, the notion that, you know, correcting misinformation might actually reinforce it or might introduce it to some people. And actually, you know, the empirical literature on this point, you know, suggests early on there were some studies in the political communication arena that, you know, seemed to suggest some possibilities for backfire. But by and large, you know, most people that I've spoken with, and if we think about the literature as it exists now, I think that case has been overstated and particularly for medical misinformation.

You can actually correct misperceptions in some cases—many cases—but to do so, you've often got to be very explicit about there having been an error. You know, for better or worse, it's not always possible to point to an explicit error. You know, and sometimes information is inaccurate because of what it leaves out. And it's sort of tough sometimes to correct an omission. So there are limited circumstances when you can actually correct, you know, misperceptions. Now the second part of your question, you know, has to do with the relationship between information and behavior. And this is one that people spend their whole career studying, you know, social scientists like me. I think there are instances in which, you know, simple provision of facts can actually lead to behavior. But there are all sorts of reasons why people act.

You know, sometimes they think that, you know, a particular behavior is a good thing to do. Sometimes they think that this is something that a loved one wants them to do, or there's a social norm in that regard. Sometimes, you know, they have the right information in order to be able to implement what's recommended, and sometimes they don't. You know, they don't know where the vaccine clinic is or what time it's open.

Amori: Humm. That's true, too.

Southwell: Right. And so, you know, there are all kinds of things that account for behavior, and it's not just a response to a limited set of facts. But what we're doing in terms of debunking, you know, myths or busting myths, we're often focusing on a limited number of fact, those facts. And so, we have to better account for the factors which predict behavior if we want to change the

behavior. And so behavioral science is really much broader than any given fact, and yet a lot of our effort is really often focused on, you know, making sure we address this fact or that one. It's complex, but I think that, you know, there's a broad array of considerations for us to take into account.

Amori: Well, Brian, you've mentioned a really big thing that I think about often as teaching communication is fear. And, Robert, you've dealt with that with the population disparities. Fear—it's impossible to counter fear with facts. Fear is not rational, and what do you see given diverse populations that the methods that healthcare clinicians can use to engage people on a one-to-one basis, so that maybe to get past the fear?

John Robert Bautista, RN, MPH, PhD: Yeah, I think one of the crucial aspects that clinicians can foster during conversations is trust. For instance, I and my colleagues published an article in February this year, the *Journal of Graduate Medical Education*, wherein we provide several methods to address health misinformation during clinical encounters. One approach that we recommend is doing motivational interviewing, which is a nonjudgmental active listening framework in which the interviewer—for instance, in this case, let's say a medical doctor—demonstrates empathy for the patient, validates their feelings, their beliefs, and concerns, develops trust, and provides correct information through respectful dialogue.

So I'll just give you an example on how this goes. So, for instance, a person has checked into the clinic, and for any kind of health reason, then the clinician observed that this child didn't really have any kind of vaccination. So, a doctor can ask, has your child received any vaccines? Then let's say that the child has different vaccines but didn't have any COVID vaccine. So you can further, as discussion, may I ask why not the COVID vaccine?

Later on, depending on what's the answer of a patient, whether let's say, in the case that the parent is hesitant, we can actually do another prompt wherein, may I share with you some information about COVID vaccine? It is important, you need to get permission. If they say yes, they're interested, so you share trustworthy information about COVID vaccine. Then you ask this question, which, is after hearing that, would you like to vaccinate your child against COVID today? And let's say that if not, then you proceed that, if not, you're welcome to return anytime you change your mind. And finally, acknowledge them that, thank you for letting me share what I know. So that is one example doing motivational interviewing.

Amori: Okay, that's good. That's really helpful. Brian, we know that everybody can go to the internet to get everything. And one of the complaints I hear from physicians is, I hate all this stuff they find that has nothing to do, it's not, you know, it's not relevant. How best can healthcare clinicians help guide patients to seek out fact-based medical information on social media? Is there a short technique they could use?

Southwell: Yeah. A lot of Robert's advice actually resonates with some of what I'll have to say here, as well. We've had a lot of experiences working with healthcare providers at Duke University where I also teach in addition to working at RTI International. And there, at Duke, we founded something known as the Duke Program on Medical Misinformation where we offer, you know, training for clinicians regularly. So these issues come up, you know, quite a bit. And I

think, you know, the key really is in respecting patients' intentions and their values first, you know, asking the questions about what's most important to them and using that as a basis for which you're going to guide them in various ways. It's going to be a lot easier to guide people to credible sources if you have a sense of what their concerns are that you're trying to, you know, that you have a reason for guiding them certain places.

Beyond that, though, I think, it also can be very useful, generally speaking—this is good advice for all of us, really, in this moment in life—when you see something that's too good to be true, you know, you see something that's sensational, you know, pause and take a breath. Think about whether there are other places you might turn to, you know, to look for information to validate that. Encourage, you know, patients to ask questions, you know, when they have them. I mean, of course, there aren't hours and hours available in most medical encounters, but there are, you know, opportunities to, you know, communicate to patients electronically, for patients to contact, you know, physicians or follow-up, you know, sometimes.

And so, the other last point here I want to raise though—this is something that comes up often in our workshops—healthcare providers/clinicians, you know, generally sometimes will be disheartened by the amount of misinformation that they see their patients bring to them. And I just think we ought to turn that around and reframe that. Because having a patient bring misinformation to you isn't a failure. Actually, it's a victory. And what I mean by that is that that patient trusted you enough to at least bring that misinformation to you—that's a start. That's a place to start because it's better to have them talking to you about it than to have them privately engaging with that information and never bringing it up to you at all. And so, actually, we think that it's not the best news in the world to have that happen, but at least it's a place that you can build on in terms of your future relationship.

Amori: Excellent. Excellent. Excellent. Thank you, Brian. All right, Robert, I know that there are different methods that can be used to gently dissuade misinformation. You've talked about that. And one of them that you use is called fact-warning-fallacy-fact. Can you explain it like in two/three sentences just sort of what that kind of looks like?

Bautista: Yeah. The fact-warning-fallacy-fact model is one of the strategies used to counter health misinformation, particularly on social media. And the CDC has a webpage featuring it. So this is somewhat endorsed, as some might say, by the CDC. For instance, the fact-warning-fallacy-fact model starts with focusing on the fact wherein, like, for instance, COVID-19 vaccines will not make you sick with COVID-19. And there's always some sense of a warning wherein there are some highlights that there is misinformation that's spreading about it. And you actually mention the fallacy that it will not give you COVID-19. You can add in some explanations why. Then you end the conversation for that social media post with another fact, which reinforces the main fact that you stated earlier.

So, let's say that vaccines teaches your immune system to recognize the virus, and it wouldn't give you any sort of disease like COVID-19. So the key here is to start with fully defying the fact and the statement with another fact. What happened back then was that the WHO made corrections to health misinformation involving COVID, but they initially highlighted on the misinformation and not on the fact. So what happened [is] that people remembered the

misinformation instead of the fact. So the fact-warning-fallacy-fact emphasizes more on the fact rather than receiving the misinformation. So, to some extent, you don't really want to publicize the misinformation because bad publicity is still publicity.

Amori: Okay. Well, that's good information. Michelle, you know, we've been talking about all kinds of platforms and media and stuff. I know this could be a whole speech in and of itself, but can you kind of briefly tell us, do you think there are risks—as well as benefits—to healthcare people having their own media sites, like Twitter sites or media presence?

Mello: Well, since we're having a conversation today about countering misinformation, I'm going to assume you mean sites that would help in that rather than sites which some physicians have that actually spread misinformation. So, is it a good idea for a physician to have such a website or to use their Twitter account for that purpose? You know, I think I would say, first of all, depends on their role because there are many physicians who have other roles, as well. They are scientists. They are public health professionals. And part of their core professional role is to speak publicly, as a public intellectual, and to translate information to the public. And, you know, there, certainly, different social media channels being generous with reporters who want to speak with you, can all be ways to combat misinformation.

I think that the one cautionary note, I guess, that the lawyer in me wants to sound is that it feels so important to try to be helpful that we can step beyond our role. That we have expertise that is often sometimes quite, you know, specialized, and what we're being asked to do, in terms of public speech, is a little bit outside our wheelhouse. So, I think it's always important to ask, do I really have the expertise and the evidence to say something about this and feel confident that it's absolutely correct. And if one of those two things—the expertise or evidence—is missing, then maybe err on the side of passing that invitation along to somebody who has that.

The other thing I would say is that, you know, for physicians who are primarily or solely in a clinical role, I'm not convinced that posting social media posts or even having a website on your practice page that provides accurate health information is the optimal way to communicate. And I, you know, would defer to Robert and Brian on this point—they're the experts—but, you know, I think that we have all learned over the past 3 years that there remains a power in face-to-face conversation, there remains a power in communicating information in the context of a physician/patient relationship interaction. And so if the goal is to reach a lot of people, you know, certainly there are health centers who have used emails or other, you know, at least somewhat more targeted forms of information conveyance to reach out to them, rather than sort of putting some post or op-ed up for everybody to see. But, you know, these are areas where just using your judgment about how to reach people in your practice best is going to pay off.

Amori: Thank you. All right in two sentences, what's the one thing you want our listeners to takeaway today, if you have one point for them to remember? Let's start with you, Michelle.

Mello: Well, harkening back to our earlier exchanges about CPS, I just want to emphasize how much good work has been done, as Robert and Brian have been describing, on strategies for counting misinformation through counseling. And I would really encourage physicians to use those resources rather than trying to wield legal weapons, except in very extreme cases of child

endangerment. And to add to the resources they've already pointed to, the American Academy of Pediatrics has what I think is quite a good webpage called "Talking with Vaccine Hesitant Parents" that summarizes a lot of research on motivational interviewing and other techniques.

Amori: Great. Thank you, Michelle. Robert.

Bautista: Yeah. To our listeners, if you are not confident to correct medical misinformation, the least that you can do is to report it on social media platforms. So social media platforms give you the capability to report a certain post, and that is one way that we can stop the spread of medical misinformation.

Amori: Oh, that's good. Thank you. And Brian.

Southwell: Yeah. So if you're a healthcare professional, you know, I just want to keep in mind that if a patient brings misinformation to you, it might be disappointing and disheartening, but it's not necessarily failure. In a lot of ways, it's a victory because of what it signals about your relationship with a patient.

Amori: Excellent. Wow, that's good news, too. Thank you very much, Brian. So, thank you to our panelists. Thank you, everyone, for joining us today. Thank you with special thanks to our panelists for a very stimulating conversation and sharing your perspectives. And see everyone next time at *Perspectives 360*.

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