ZOOMRX

The Conversation Behind the Vaccine

What real exam room data reveals about how patients actually decide— and what brand teams can't get from any other source.

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READING TIME

15-20 minutes

ABOUT THE AUTHORS

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Vincent Valant is the product manager for HCP-Patient Conversations at ZoomRx, where he leads the best-of-class observational point-of-care research methodology based on real-world audio recordings of clinical doctor-patient interactions. With over a decade of experience in pharmaceutical market research, he specializes in capturing what actually happens in the exam room and translating it into patient-centric intelligence that life sciences companies can act on.

Vincent has helped shape ZoomRx's HCP-Patient Conversations methodology to organically capture unbiased real-world clinical conversations, surfacing key moments of truth through an interactive portal with AI-powered navigation for direct access to the patient experience. HCP-Patient Conversations is built on the belief that healthcare decision-making is a fundamentally human experience, and that making patient voices heard is the fastest path to improving it.

135+
Projects delivered

20
MD specialties

800+
Unique HCPs

ABOUT THE AUTHORS

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Rokesh Palanisamy is a Product Consultant for HCP-Patient Conversations at ZoomRx, focused on building the operational and analytical infrastructure that support the consulting teams running HCP-Patient projects. He bridges product strategy with technical execution, designing AI-driven workflows that accelerate everything from survey design to insight delivery.

Rokesh is the architect behind HCP-P's agentic AI layer — building intelligent systems that help navigate the dataset and enable our team of expert consultants to operate at scale without sacrificing depth. His work is grounded in the conviction that the best research platforms don't just collect data — they think alongside the people using them.

143,000+
Conversation snippets analyzed via Galen

4,800+
Themes powering the AI layer

100+
Indications covered

Executive Summary

Somewhere in a primary care office this week, a physician will do everything right. She will check the chart, note the patient is 52 years old, and bring up pneumococcal vaccination exactly as she was trained — citing CDC guidelines, explaining the one-time dosing, connecting it to the patient's age. The patient will nod along. And then, at the moment of decision, the patient will say: "Maybe next month."

The physician will make a note. Move on. And the conversation that determined whether that patient got vaccinated will be gone — unheard, unanalyzed, invisible to the pharma team that spent years building the clinical case and the messaging strategy that preceded it.

This is the gap at the center of vaccine commercialization. Pharma teams have detailed data on what physicians know, believe, and report prescribing. What they rarely have is what physicians actually say — and what patients actually say back. Those two things are not the same. And the distance between them is where vaccine decisions are made and lost.

In this piece, we draw on ZoomRx's HCP-P conversation data from real clinical vaccine appointments to map the anatomy of the vaccine decision — what physicians say to open the topic, how patients respond, and precisely what separates a same-visit acceptance from a deferral..

What the Data Doesn't Capture

The standard market research toolkit for vaccines is built around the physician's conscious mind. NRx data tells you what gets prescribed. Message recall surveys tell you what physicians remember from a rep visit. ATU studies tell you where a product sits in the treatment hierarchy. All of it is retrospective, all of it is self-reported, and none of it captures the conversation that actually happens when a patient is sitting in the exam chair.

That conversation — the real-time, unscripted exchange between a physician and a person deciding whether to accept a needle today — is the last mile of vaccine delivery. It is where clinical evidence, HCP education, and promotional investment either convert into a vaccinated patient or don't. And it has been, until recently, a black box.

ZoomRx's HCP-P methodology captures it directly. Real clinical conversations are recorded with patient and physician consent, transcribed, and analyzed across themes, language patterns, and decision outcomes. The database spans multiple therapeutic areas. For this analysis, ZoomRx analyzed physician–patient conversations across vaccine populations.

What we found does not contradict what pharma knows about vaccine recommendation. It reveals what happens after the recommendation — in the exchanges that pharma has never had direct access to..

Vaccines Are a Shared Decision — Whether Physicians Like It or Not

Most pharmaceutical products reach the patient through a physician's pen. The patient is informed, the prescription is written, the decision is largely physician-led. Vaccines are different. A vaccine requires the patient to say yes, in the room, that day. It requires active consent, often under time pressure, frequently without the context of an acute illness to make the urgency feel real.

Post-COVID, this dynamic has intensified. Hesitancy has broadened well beyond the philosophical opposition that once defined it. In ZoomRx's vaccine conversations, the most common hesitancy is not "I don't believe in vaccines." It is:

> **PATIENT**
>
> *""I was thinking about it, was kind of afraid to take it, to get it. Is there any side with it?"*

Or this:

> **PATIENT**
>
> *"Honestly, I don't know if I should continue to keep on getting all of the boosters that are coming out periodically."*

This is mainstream hesitancy — cautious, deferral-prone, and eminently addressable. The physician who can navigate it in real time converts it. The physician who cannot leaves the exam room with a chart note and a patient who never comes back for the shot.

For pharma vaccine teams, this creates a specific and underappreciated design challenge: not what should physicians know, but what should physicians say — and when, and in what sequence — to convert hesitancy into acceptance.

Three Acts, One Decision

Across the ZoomRx vaccine conversations, successful vaccine acceptance follows a recognizable three-act structure. This is not a prescribed protocol. It is a pattern that emerges from the data — what physicians who achieve same-visit acceptance consistently do, in sequence, that physicians whose patients defer do not.

Act 1: The Opening Frame

The first thing a physician says about a vaccine is rarely a product name or a clinical data point. It is a frame — a reason for the patient to pay attention before the recommendation is even made.

Three opening frames appear consistently in the data. The first is **authority anchoring:** citing CDC guidelines to establish that the suggestion comes from a source larger than the physician's personal opinion.

> HCP
>
> *"The pneumonia vaccination is a newly recommendation from the CDC. It used to be that the age threshold to initiate pneumococcal vaccinations was 65. Luckily, it's just a one-time shot, not like your COVID and flu vaccination."*

The second is **life-stage framing**: connecting the vaccine to an age milestone that makes the recommendation feel timely rather than generic.

> HCP
>
> *"I want to talk to you, since you're over 50 years of age... even when you don't have any medical conditions like diabetes or heart disease or kidney disease, it is recommended that you take this vaccine."*

The third is **transition framing** for younger patients: using a life event — college enrollment, entering a shared living environment — as the natural trigger.

> HCP
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> *"When you're going into college because it's a community setting — the CDC, any of the medical societies — one of the big recommendations for people going into any group setting, again, college or dorms or just classrooms, the military — is to get a meningitis vaccine."*

What is notable about all three frames is what they are not. No physician in this dataset opened with the vaccine's mechanism of action, efficacy percentages, or differentiating characteristics. The clinical facts came later, or not at all. The frame — the reason to listen —came first.

Act 2: The Hesitancy Moment

In nearly every conversation, the patient responds to the recommendation with something other than immediate acceptance. In some conversations this is a direct question. In others it is a soft deflection. But the hesitancy moment is present in almost every exchange, and its content is more predictable than most pharma teams assume.

Side effect fear is the most common hesitancy in this dataset, appearing across both vaccine types and HCP specialties. Vaccine fatigue is the second most frequent, particularly among older patients navigating multiple recommended vaccines in the post-COVID period. Scheduling deferral — the "maybe next month" response — is the third, and the most underestimated, because it presents as acceptance while functioning as decline.

> **PATIENT**
>
> *"Yeah, we'll wait. Maybe in the next month or so, I'll consider it."*

The critical insight here is that hesitancy is not refusal. In the vast majority of cases, it is a request for reassurance. What happens in the next 60 seconds of the conversation determines the outcome.

Act 3: The Response Strategy

This is where the data diverges most sharply from what pharma materials typically train for— and where the most actionable insight lives.

Physicians who achieve same-visit acceptance do not, in general, respond to hesitancy with more clinical information. They do not cite trial data, reinforce efficacy numbers, or escalate the recommendation. They do three things: they normalize the concern, they anchor it to something familiar, and they address the question the patient has not yet asked.

Normalization sounds like this:

> HCP
>
> *"Well, with any vaccine, you can feel a little bit sick after — it's just your immune system making a response. So when we make antibodies, sometimes that can mimic a flu-like illness. So you might feel like that for the first 24 hours, but most people tolerate it really well."*

Comparative anchoring sounds like this:

> HCP
>
> *"The side effects are not any different really than the meningitis A one that you got. So a little pain where the injection goes in. Like all vaccines, it can make you feel a little rundown, but that shouldn't really last over 24 hours."*

And lifestyle continuity reassurance — the intervention that appears most consistently in the moments immediately before acceptance — sounds like this:

> HCP
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> *"You can do everything regular. Of course. Go to the gym. Eat normal. You could drink."*

This last category is the most counterintuitive finding in the dataset. Patients are not primarily worried about whether the vaccine will work. They are worried about whether

it will disrupt their Wednesday. Physicians who proactively addressed this — without being asked— resolved hesitancy faster and with less back-and-forth than those who stayed on clinical ground.

The Numbers Behind the Conversation

The vast majority of patients across vaccine types accepted the recommendation at the visit where it was made, ranging from 3 in 4 patients accepting same-visit vaccines to 9 in 10. About 1 in 6 deferred — expressing interest but not committing on the day — while a small minority declined outright. The difference tracks to three factors visible in the conversations: the life-transition frame creates natural urgency that some indications lack; severity messaging landed harder in meningococcal discussions "It can actually kill you," and a younger patient demographic are generally more comfortable with preventive medicine visits.

Deferral patterns are consistent in what caused them: absent urgency framing. Patients who deferred had, in most cases, been given all the clinical information they needed. What was missing was a reason to act that day. The physician who said "Okay, so it's called Prevnar 20. We have it in the office. So if you want that, just think about it, just call my nurse" left the patient fully informed — and fully uncommitted.

Decline patterns are less recoverable. Past negative vaccine experience and identity-level opposition — "We're not those vaccine-taking people" — appear in a small share of conversations and are largely resistant to the standard response strategies. These patients are not asking for reassurance. They are expressing a value, and the conversation requires a different kind of tool.

The single most decisive procedural factor in same-visit acceptance: physicians who asked directly — "Do you want to get the vaccine today?" — consistently outperformed those who left the decision implicit. The close matters.

What This Means for the Teams Designing the Conversation

The patterns in this data carry concrete implications for the pharma teams that build HCP training programs, design field messaging, and develop medical affairs materials for vaccine brands.

Train for Act 2, not Act 1

The vast majority of HCP training investment focuses on the recommendation — the data, the guidelines, the clinical rationale. The conversation data shows the decision is made in the hesitancy response, not the opening recommendation. Physicians who handle Act 2 well achieve near-universal conversion. Physicians who move quickly past hesitancy, or respond with more clinical information rather than reassurance, see deferral rates climb. Training programs that do not simulate the hesitancy moment — and coach physicians through it — are optimizing for the wrong part of the conversation.

Add Lifestyle Continuity to Side Effect Messaging

Standard side effect briefings prepare physicians for the question "what might happen to me?" The conversations reveal that patients are equally concerned with "will I be able to live my normal life?" These are different questions with different answers, and the second one is almost never addressed in HCP support materials. A physician who can say "you can go to the gym, eat normal, and you don't need to cancel anything" — proactively, before the patient asks — removes the most common logistical barrier to same-visit acceptance.

Audit your Urgency Framing

Deferral is not driven by negative sentiment about the vaccine. It is driven by the absence of a reason to act today. If the physician's message — as designed by the pharma team — does not give the patient a specific, present-tense reason to accept the vaccine at this visit, the message is functionally designed for deferral. The question to ask of every piece of HCP support material: does this give a physician something to say when a patient responds "maybe next month"?

Distinguish between Hesitancy Types before Designing for them.

Side effect fear is the most common hesitancy and the most recoverable. Past negative experience and philosophical opposition require fundamentally different responses. The conversation data can segment hesitancy types by language pattern and decision outcome, giving vaccine teams a map of which patients need which intervention. Designing a single response to "hesitancy" misses the variation that makes some hesitancy easy to address and some nearly impossible.

> *The vaccine decision is not random. It is not purely a function of how well a physician was trained or how strong the clinical evidence is. It is a conversation — structured, predictable, with recoverable failure points and a consistent path to acceptance.*

Pharma teams that understand this structure can design better HCP support tools, better field messaging, and better training programs — grounded not in what physicians report saying, but in what they actually say.

If your vaccine brand is navigating the gap between what physicians know and what they say in the room, ZoomRx would welcome the conversation.

ZOOMRX

ABOUT ZOOMRX

ZoomRx is a life sciences strategy consultancy that captures and analyzes real physician-patient conversations across therapeutic areas. To learn more about HCP-P conversation research, contact your ZoomRx representative or visit zoomrx.com.

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