

Physician Communication With Vaccine-Hesitant Parents: the Start, Not the End, of the Story

Julie Leask, PhD, MPH, Dip App Sci^a, Paul Kinnersley, MB ChB, MD, FRCGP^b

In this month's issue of *Pediatrics*, Henrikson et al¹ report a trial of the impact of communication training for physicians on the vaccine hesitancy of parents. The authors found that a physician-targeted communication intervention did not reduce vaccine hesitancy in mothers nor improve physician confidence compared with standard care. However, the study requires careful interpretation and should be seen as the start, not the end, of the story in finding effective approaches to vaccine hesitancy.

There is a clear need to develop new approaches to vaccine consultation. Although only 0.7% of children in the United States are completely unvaccinated, an estimated 13% of parents delay or select out of certain vaccines,^{2,3} and the risk of this choice is enhanced by geographic clustering, creating a critical mass for disease outbreaks.⁴ Even parents who fully vaccinate have some concerns (eg, the number of vaccines, the vaccine ingredients, whether they potentially "damage" the immune system).^{5,6}

To address vaccination concerns, hesitancy, and refusal, some advocate a tougher line with strong physician recommendation, little room for expression of concern, and even denial of care to vaccine-refusing families. For example, the survey by Kempe et al⁷ of 696 pediatricians and family medicine physicians found that 10% would always or often dismiss families if they refused vaccine in the primary series for their child. Giving a vaccine recommendation comes with some

empirical support, with studies finding a strong association between physician recommendation and vaccine uptake.⁸⁻¹⁰ In addition, Opel et al¹¹ found that "presumptive" communication (language that conveys an assumption that the child will be vaccinated) was associated with better compliance with vaccinations within the same visit but reduced parental satisfaction. The study by Henrikson et al¹ could also be interpreted as providing support for a presumptive approach because it found no benefit from an intervention that trained clinicians to encourage parents to ask questions and express concerns. However, the training for the physicians in the intervention group was short (ie, 45 minutes) and part of this time was spent on didactic presentations. Training of short duration without a practical component and feedback would not be expected to change physician behavior, and thus the approach may be effective if delivered differently.¹²

Although many would dismiss parental satisfaction if it comes at the expense of a fully vaccinated child, a presumptive approach with vaccine-hesitant parents may reduce trust and possibly schedule completion in the longer term. A systematic review showed that lower vaccine uptake was linked to a perception that the discussion with health professionals about immunization concerns was inadequate in length and depth, dismissive, and difficult.⁴ Another found that parents want opportunities to ask questions but do not always feel

^aSchool of Public Health, University of Sydney, New South Wales, Australia; and ^bInstitute of Medical Education, Cardiff University, Cardiff, Wales, United Kingdom

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Address correspondence to Julie Leask, PhD, MPH, Dip App Sci, School of Public Health, Edward Ford Building, A27, University of Sydney NSW 2006, Australia. E-mail: julie.leask@sydney.edu.au

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confident in doing so.¹³ The opportunity to ask questions also supports the process of valid consent. More broadly, the vaccination consultation is also a community intervention because parents will talk with each other about their experiences at clinics.

Communication interventions are only effective if physicians effectively take them up. Time for training is problematic because “real-world” physicians do not have time for extended training; hence, the pragmatically brief approach offered by Henrikson et al.¹ However, too small a dose of training will have no impact even if the intervention could work under ideal conditions.

Decision aids may change the consultation script while requiring relatively little physician training. They are designed to help people understand their options and potential outcomes, to consider the possible benefits and harms of their choices, and to increase consumer participation in decision-making.¹⁴ A UK study found a decision aid given to parents before their measles-mumps-rubella vaccine consultation was effective in improving decision-making, resulted in 100% compliance with this vaccine, and was cost-effective.^{15,16} Abbreviated versions of such tools offered to vaccine-hesitant parents may be a more effective way to embed more satisfying and effective communication strategies. However, these ideas, like others, need to be fully evaluated.

The great challenge in achieving high acceptance of vaccines is to find and test interventions that lead to full compliance with the vaccination schedule and parent satisfaction and also build trust in the recommendations of physicians. These interventions need not prevent the physician from recommending vaccination but, with vaccine-hesitant parents, we suggest that this recommendation is best made in the

context of an overall guiding (rather than instructing) approach.^{11,17,18}

Physicians should aim for both parental satisfaction and a positive decision to vaccinate.¹⁹ Researchers must continue to develop conceptually clear, evidence-informed, and practically implementable approaches to parental vaccine hesitancy, and agencies need to commit to supporting the evidence base. Billions of dollars fund the research and development of vaccines to ensure their efficacy and safety. There needs to be a proportional commitment to the “R&D” of vaccine acceptance because vaccines are only effective if people willingly take them up.

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