Vaccine hesitancy is a global public health threat. The COVID-19 pandemic has illuminated already existing vaccination fears among a large subset of the world's population. When it comes to vaccination, parents and guardians make decisions for their underage children, which is no different for the COVID-19 vaccine. Research is thus critical to understanding some of the causes for vaccine hesitancy among parents of underage children. Lee et al performed a cross-sectional survey study of 113,450 parents of school-aged children 5 to 11 years old in South Korea.

Parents were recruited through notices at their child's school. Results demonstrated that only 6.5% of the parents were willing to have their children vaccinated as soon as possible. Parents who were confident in their ability to make a health care decision based on the information provided (sufficiency of vaccination information) were 3.08 times more likely to have their child vaccinated ($P < .001$). Parents who trusted the source(s) of information provided (credibility of vaccination information) and believed that the vaccine was safe and effective were 7.55 times more likely to have their child vaccinated ($P < .001$). The authors conclude that both what information is being provided and how it is being provided to parents and guardians of children in need of vaccines, in addition to who is communicating this critical information, are essential factors in parents' decision-making regarding COVID-19 vaccination. Although it is not possible to generalize these survey results to other countries, the study illustrates a growing recognition of the importance of clinicians as trusted vaccine messengers.

Antivaccination movements have existed since the 1790s, when Edward Jenner developed the smallpox vaccine in Great Britain. In the mid-1900s, fear surrounding the live polio virus and possible adverse effects triggered another antivaccination movement, and in recent decades, concern about other essential childhood vaccines, such as the MMR (measles, mumps, and rubella) vaccine, causing autism and other neurologic disorders triggered an increase in vaccine hesitancy among parents in industrialized countries.

The US Centers for Disease Control and Prevention reports that, as of October 5, 2022, only 15.4% of eligible children 5 to 11 years of age have received their COVID-19 vaccine series, including booster. Although healthy children remain the lowest-risk group for COVID-19 complications, they remain at risk for multisystem inflammatory syndrome in children (MIS-C), a rare but serious pediatric complication of COVID-19. And, from a public health standpoint, vaccination of children is probably one of the most critical elements to prevent community transmission.

The reasons for parental vaccine hesitancy are complex and may be interconnected. They include the fear of the short- and long-term adverse effects for their children, the "warp speed" of new mRNA vaccine development, the political polarization associated with how the vaccines were initially rolled out, and the misinformation regarding the vaccines' safety and efficacy profile. Many parents are worried about infertility and other reproductive complications, as well as myriad other adverse effects of the mRNA vaccines.

Quite possibly the manner in which the COVID-19 vaccines were rolled out exacerbated vaccine hesitancy. In most cases, people learned about the vaccines through news outlets, celebrities, or elected officials—not medical professionals or, ideally, their own physicians. The most recent Edelman Trust Barometer suggests that news media and political figures are among the least trusted groups globally. Although few people would directly attribute their concerns about the vaccines to how they learned about them, research suggests that how people learn about vaccines can influence their confidence in vaccines and their willingness to get vaccinated. According to further research by
Edelman, people who are unvaccinated get vaccine information from internet searches and their friends and family, while those who are fully vaccinated get information from their own physicians and national health experts.

Many strategies designed to increase confidence in vaccines—particularly among parents—focus on developing convincing messages, debunking misinformation, or increasing access to the vaccines. Although these focuses make intuitive sense and are essential to addressing the problem globally, each misses the most valuable resources in building vaccine confidence: physicians and other clinicians who have the skills to build trust with their patients. In fact, it is essential that clinicians are the main source of communication for introducing vaccines. This is not only desirable; it is essential to include clinicians in the process of introducing vaccines—particularly new vaccines.

Many studies—including the study by Lee et al1—show that parents trust their clinicians. But people also need a trusted clinician, and many, especially those living on the margins or in rural communities, do not have equitable access to health care. When there is no trusted clinician available, people must resort to an emergency department, where preventive care is not the priority. A trusted primary care clinician (and clinic) can be critical to help patients become more resilient in the face of misinformation.

Primary care clinicians also require skills and training to help people—particularly parents—overcome their fears and address misinformation. Compassionate listening, showing curiosity, acknowledging fears, and gently offering resources and stories that help people gain new perspectives may be some of the most important things that clinicians can do. Perhaps vaccine hesitancy is not really hesitancy at all but the result of a lack of enough trained and trusted clinician messengers willing and able to patiently stay the course with their patients and families, listening without judgment to their fears and anxieties.7

Clinicians can improve their communication skills and increase their confidence when talking to patients about vaccine hesitancy through active role-playing scenarios and simulation trainings that teach the importance of empathic listening and respecting the patients’ and parents’ concerns. The Vaccine Confidence Project ECHO is 1 example of a program that educates clinicians virtually in real time with a mixture of evidence-based information, simulations, and case-based learning while focusing on compassionate communication skills.

Clinicians can also provide accurate information to parents, such as communicating the percentage of patients in the practice or city who have been vaccinated. Stating that most or nearly all the parents they see in their clinics are electing to vaccinate their children will promote a positive social norm. Unfortunately, so much of the COVID-19 vaccine news coverage focuses on people who have chosen not to get vaccinated; however, the reality is that far more people with access to the vaccine are vaccinated. This kind of negative news coverage may create the perception among parents and guardians that far more people are choosing not to get vaccinated and may engender a perverse social norm that does not reflect reality. Parental love is one of the most powerful emotions humans experience. It creates a deep desire to protect vulnerable children. But that desire to protect can manifest as vaccine hesitancy or acceptance, depending on which of the 2 the parent or guardian sees as a greater threat. A well-trained clinician can listen to parents’ concerns and point them in the direction that will best protect their child.

A vaccine that people do not take is useless. The world will face more pandemics, and we have the technology to quickly develop vaccines that will save lives. Physicians and other trusted clinicians can—and should—play 2 lifesaving roles: the first as a caregiver and the second as a communicator.
Corresponding Author: Joanna G. Katzman, MD, MSPH, Department of Neurosurgery, University of New Mexico School of Medicine, One University of New Mexico, MSC 07 4245, Albuquerque, NM 87131 (jkatzman@salud.unm.edu).

Author Affiliations: Department of Neurosurgery, University of New Mexico School of Medicine, Albuquerque (Katzman); Department of Public Relations, College of Journalism and Communications, University of Florida, Gainesville (Christiano).

Conflict of Interest Disclosures: None reported.

REFERENCES


