

VIEWPOINT

The Role of Patient Engagement in Addressing Parents' Perceptions About Immunizations

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Vaccines are frequently cited as one of the greatest successes in the history of public health. The World Health Organization estimates that vaccines for diphtheria, pertussis, tetanus, and measles save between 2 million and 3 million lives annually. However, in recent years, parental resistance toward childhood vaccinations has increased.¹ Many parents have become concerned and distrusting of scientific evidence about vaccinations. As a result, cases of vaccine-preventable diseases have reemerged in the United States and other countries. Unvaccinated and undervaccinated individuals are susceptible to disease and increase the risk of transmitting diseases even to those who are fully vaccinated.¹

Physicians, nurses, and other health care professionals should increase efforts to build relationships with parents, especially when parents express hesitation or have misconceptions about vaccinations. Health care professionals are a trusted source of information and can have a positive influence on parents considering vaccinating their children, including parents who initially have concerns about vaccine safety. Many parents report that lack of trust in their health

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care professionals and dissatisfaction with their vaccine discussions with clinicians influenced their vaccine refusal.²

Clinicians and public health educators can have a strong, negative reaction to vaccine hesitancy when the science overwhelmingly suggests that vaccines are safe. However, most vaccine-hesitant parents believe they are protecting their own children. Understanding their values and being open to genuine, respectful conversations with vaccine-hesitant parents may improve patient-clinician relationships and the likelihood that vaccine evidence will be considered. In fact, 30% to 47% of initially hesitant parents may decide to vaccinate their children if clinicians continue to engage them in discussions.³

Understanding Cognitive Biases at Play

Parents are not entirely to blame for trusting "alternative facts" about vaccination. A common psychological phenomenon called the *illusory correlation* can lead parents to erroneously believe that two variables are related (eg, vaccines and autism). These beliefs may originate from or be exacerbated by pseudoscientific

articles, fake news stories generating an artificial controversy, or anecdotes from personal connections.

Once they have this illusory correlation, *confirmation bias* may lead parents to notice or recall information that confirms their preexisting beliefs and ignore other messages. *Motivated reasoning* may lead parents to seek out additional support for their preexisting beliefs, rather than search objectively for data. Social media and the internet may perpetuate these two biases by bringing together people who share these opinions.

Another phenomenon called *omission bias* may help to explain some concerns about vaccination.⁴ People often feel guiltier committing an action (doing something that could cause harm) than omitting an action (failing to do something that then leads to harm). For example, a parent might feel guiltier if a child develops a high fever after receiving an influenza vaccination than if a child contracts influenza after not vaccinating. The parent might justify contracting influenza as a "force of nature" but might blame himself or herself for contributing to the fever by having the child receive the influenza vaccine. This bias persists even when the actual risk from omitting an action (failing to vaccinate) is greater than the risk of committing an action (vaccinating). It may be even stronger when individuals feel *anticipatory regret* should vaccination lead to a poor outcome.⁵ Social media and health blogs can contribute to these biases by reporting stories of people's concerns and adverse effects from vaccines.

Respectfully Engaging With Vaccine-Hesitant Patients

Parents might have different reasons for vaccine hesitancy. Clinicians might want to match their specific messages to parents' initial readiness to vaccinate. However, the following broad strategies may be effective.

First, identify common ground. Because most parents and their clinicians want to keep children safe and healthy, acknowledging this value is an important place to begin a conversation. This process may help both parties connect with a shared goal and then talk about their different perspectives on how to reach that goal. Before countering the illusory correlation with evidence, clinicians could start by listening to better understand parents, not just to persuade. Next, they could empathize with parents and say, "Like you, I was so worried about my child's health and safety, especially when she was a newborn. I just wanted to make the right choice for her health. Here is what

helped me decide to vaccinate when I was weighing the pros and cons of vaccination.”

Second, couple evidence with compelling narratives. Medical and public health communities often use research, statistics, and other evidence-based information to discuss vaccination. However, compelling narratives are more memorable than statistics and can be more persuasive than facts alone. It may be useful to provide both stories and evidence when engaging with vaccine-hesitant parents.⁶ Stories that help patients visualize potential negative outcomes of skipping vaccinations and those that model anticipated regret that a parent might experience after omitting vaccinations if a child were to contract a vaccine-preventable disease could be especially powerful.⁷ For example, clinicians could discuss the risks of contracting a vaccine-preventable disease compared with the risks of a vaccine-related adverse effect, coupled with a story about a patient who contracted a vaccine-preventable disease.

Third, clarify values. Values clarification techniques in patient-centered care (achieved through shared decision making or motivational interviewing) can help clinicians better understand parents' beliefs about health care. These open-ended questions come from a place of patient partnership rather than judgment. Discussing values does not suggest that clinicians should waver on their certainty about the need for vaccinations. One study found that asking patients questions such as “Are we going to do shots today?” led to a significant decrease in willingness to vaccinate compared with

stating with confidence, “We'll do three shots today.”⁷ Thus, after asserting that there are vaccines to administer during a visit, if clinicians sense hesitation, they could ask “What is the most difficult part about deciding whether or not to vaccinate? What concerns you most about vaccinating?” The clinicians can then directly focus on evidence and narratives that address those concerns.

Fourth, provide resources to critically evaluate news stories. Websites can help parents critically examine news stories to uncover biases and inaccurate reporting in the media.⁸ Many people search for health information online to supplement advice from a clinician. Having evidence-based online resources can help parents feel more engaged in their health decisions overall.

Ultimately, patients control their own health decisions, including whether to have their children vaccinated. Dismissing a patient or parent when he or she questions evidence-based recommendations may lead to more polarization of ideas. Engaging with patients can build patient-clinician relationships and can help both parties understand each other's perspective. Some patients may continue to refuse vaccinations even after a clinician engages in a conversation, and many clinicians at that time may decide to dismiss unvaccinated patients to protect their vulnerable patients who are too young or are medically unable to be vaccinated.³ However, building relationships with patients, directly addressing their concerns, and demonstrating confidence about vaccine safety may ultimately lead to improved vaccination rates over time.

ARTICLE INFORMATION

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