

AAP Policy on Vaccine Hesitancy Glosses Over Real World Solutions



By *Jamie Wells, M.D.* — August 31, 2016



The American Academy of Pediatrics convened a committee to guide clinicians on “Countering Vaccine Hesitancy” among parents. This policy statement, [published in the journal *Pediatrics*](#) ^[1], rightly champions vaccination as “one of the greatest public health achievements of the last century.” In a calculated effort not to reduce the conversation to a pro- versus anti-vaccine one, the leading pediatric advocacy body correctly opted to emphasize “vaccine hesitant” as a more precise reflection of the spectrum of parental views toward immunization. According to a survey they conducted, 75% of pediatricians reported encountering parents who refused vaccines in 2006 compared to 87% in 2013. They further demonstrate a rise in refusal over that 7-year interval. States with non-medical exemption options possessed the highest numbers. As a result, the committee firmly supports working to eliminate them.

There is just one problem; pediatricians actually don't need more guidelines and protocols. An irrational amount of our time is already spent discussing vaccines when there are a lot of other issues we are going to be concerned about in a family visit. More on that shortly. First, let's talk about what they did.

The report successfully underscores the importance of immunization. It reiterates that with global travel, vaccine preventable disease spreads quickly and warrants on-time administration as the most effective way to protect the masses. The AAP also rightly notes that increased engagement by the physician correlated with an increase in vaccine acceptance. They accurately assess the heterogeneity of the vaccine hesitant parent and convey it is crucial to alter approaches to their unique concerns. It seems most vaccine-hesitant are responsive to information delivered by their caregiver.

The stage is set to make pediatricians the difference makers, and that is true.

Yet they fail to see that it's easy to draft a policy and ignore the reality of a busy medical practice.

The report dedicates a mere few paragraphs to physician visit solutions and contradicts itself in the process. With tremendous variability in patient volumes and practice-dependent expectations, the recommendations fall short on realistic guidance a practice can employ to free up time - a requisite component to the ongoing vaccine conversation and development of a trusted rapport.

The paper affirms “providing vaccine information is time consuming” and “pediatricians experienced decreased job satisfaction because of time spent with parents and significant vaccine concerns.” The office visit does not service the vaccine discussion in a vacuum. There are competing interests each and every appointment. It is of limited duration and must include assessment of birth complications to monitoring of congenital heart disease to ensuring normal neurological development, for example. The pediatrician is expected to analyze the psychosocial family dynamic, follow up on newborn screening tests, educate on proper nutrition/feeding while examining proportionate growth and, again and again, hourly and daily speak of vaccines.

The solutions offered are oversimplified, so let's deconstruct:

1) “physicians have several options to deal with this problem, ranging from scheduling longer well-care visits, with some loss of overall efficiency”

As more physicians are salaried and employed by hospitals, the ability to alter their schedule is often not in their control. Job constraints necessitate seeing specified volumes per day. The advent of EMR limits the number of patients a physician can see while increasing work load.

The vaccine hesitant families absorb a significant amount of physician time with the topic often hijacking acute and subacute issues. Other disease entities and follow-up procedures compete for time.

2) “simply not having the discussion and acceding to a parent's request to defer, delay or skip vaccination”

Unlikely, given regulations of informed consent and oath to do no harm. Methods to minimize fatigue and redundancy with pediatrician would be useful as these conversations are ongoing, not traditionally a one off.

3) “permitting alternative vaccine schedules reduces vaccine timeliness & complicates an already complex vaccine schedule...situational deviation from these recommendations may be considered as last resort”

Disagree. Often, in practice, after a parent agrees to one or two shots and witnesses no ill effects it is this reality-testing and affirmation that can be the catalyst to go ahead with the full schedule. It underestimates the time needed to develop a trusted relationship which that extra visit or two enables.

4) “or, dismissing families from their practice.”

Though the AAP is very clear this option is a last resort and must meet specific criteria, this action

can have ramifications and a complexity of ethical issues for the physician in practice. It is a lost opportunity. The statement “**However, there is anecdotal evidence that when pediatricians give parents the choice between immunizing their child or being dismissed, some parents accept vaccination even when other efforts at persuasion have failed**” is in conflict with concepts of shared decision making and patient autonomy. It is a coercive slippery slope that can erode the doctor-patient relationship and bond formed.

The AAP policy dismisses more visits with the pediatrician as costly and defines as decreased efficiency of provider. They can't have it both ways. I would argue the cost of this is likely less than the cost to manage disease and, subsequent, outbreak. Methods to increase time and repetitive visits with the pediatrician establish a lasting and trusted bond—the forefront of the therapeutic patient relationship.

Research that, AAP.

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[1] <http://pediatrics.aappublications.org/content/early/2016/08/25/peds.2016-2146>