Tips on Dealing with 'Vaccinophobic' Parents

A personal physician recommendation for a vaccine is one of the most critical influences.

BY BRUCE JANCIN

EXPERT ANALYSIS FROM A CONFERENCE ON PEDIATRIC INFECTIOUS DISEASES

VAIL, COLO. — Never underestimate the power of a physician's strong personal recommendation of a vaccine in influencing a parental decision to get their child vaccinated and perhaps themselves as well.

"It has been shown time and time again in multiple studies that one of the most critical factors in parents' acceptance of vaccines either for themselves or for their child is a personal physician recommendation for that vaccine," Dr. Marsha Anderson said at a meeting sponsored by the Children's Hospital, Denver.

This point has been brought home in studies involving several different vaccines, most recently in a national survey regarding uptake of the 2009 monovalent vaccine against pandemic H1N1 influenza, noted Dr. Anderson, a pediatric infectious disease specialist at the hospital and the University of Colorado.

The C.S. Mott Children's Hospital National Poll on Children's Health conducted a national survey of H1N1 vaccination rates as of January 2010. The survey, conducted by professional pollsters on behalf of the hospital, which is a part of the University of Michigan Health System, included a nationally representative sample of 2,246 adults. The results showed that as of last January, 29% of children and 16% of adults had received the pandemic H1N1 vaccine.

Among the 38% of survey participants who reported that their child's health care provider strongly recommended the vaccine, the vaccination rate was 66% in their children and 57% among the parents themselves.

With less emphatic endorsements by the physician or another health care provider, vaccine uptake rates fell off sharply. For example, when parents reported that their child's health care provider "somewhat" rather than "strongly" recommended the H1N1 vaccine, the vaccination rate was 30% for their children and 19% for the adults.

And when the health care provider was seen as "neither for nor against" the H1N1 vaccine, as was the case for the physicians of 35% of the children and 55% the adults, the vaccine uptake rate plunged to 11% among the kids and 7% for adults.

When Dr. Anderson polled her Vail audience, composed mainly of general pediatricians and family physicians, as to how frequently they experienced frustrating conversations with "vaccinophobic" parents regarding immunizing their children, 35% indicated it happened at least once per day on average, and another 37% said it occurred 3-4 times per week. So this is an issue that commands a considerable amount of most physicians' time.

Just what physicians are running up against was emphasized in a recently published survey of a nationally representative sample of more than 1,500 parents. Fifty-four percent strongly agreed with the statement, "I am concerned about serious adverse effects of vaccines." One-quarter of parents believed some vaccines cause autism, a figure that climbed to 37% among Hispanic parents. Particularly disturbing, in Dr. Anderson's view, was the finding that 11.5% of parents had refused at least one physician-recommended vaccine (Pediatrics 2010;125:654-9).

Among parents who had refused the measles-mumps-rubella (MMR) vaccine, 42% indicated they didn't think enough research had been done on the vaccine. This was also the case among 55% of those who refused the varicella vaccine, 67% who declined the meningococcal vaccine, and 78% of parents who refused the human papillomavirus (HPV) vaccine.

The take-away lesson from the H1N1 vaccination survey, Dr. Anderson said, is that in counseling parents who question the need for immunizations, it's important to take the time to explain why you personally recommend the vaccines for your patients—not just that it's a national recommendation and therefore it is the right thing to do, but why it's going to benefit their child.

This conversation also needs to include an explanation of the benefits versus the sometimes exaggerated risks of immunization, including the importance of maintaining herd immunity, as well as a description of the vaccine approval process in the United States and the mechanisms in place to monitor vaccine safety, such as the Vaccine Safety Datalink and the Vaccine Adverse Event Reporting System, she said.

A Kaiser pediatrician in the audience said her HMO's research indicates that many parents have the misconception that physicians make a lot of money by prescribing vaccines, and that's why they encourage children to get them. It's a good idea to address this issue directly. "They don't believe what we're saying."

Audience member Dr. Vincent A. Fulginiti, a former chair of the National Vaccine Advisory Committee of the U.S. Public Health Service, commented that in dealing with dissatisfied parents' organizations on a national level, he's noted that institutional distrust is a recurring theme.

"I've seen it repeatedly in the leaders of the antivaccine movements. They think that we're lying, that we cheat both at the vaccine manufacturer level and at the immunization committee level," said Dr. Fulginiti, who is chancellor emeritus at the University of Colorado Health Sciences Center.

He added that another recurring theme in the antivaccine organizations is a lack of scientific understanding: "In trying to explain biologic plausibility to them, the parents don't seem to get that."

Dr. Anderson said many parents who question the need for vaccines love to do their research at what she called "the University of Google," where they can encounter some pretty biased and inaccurate sites that focus on rare negative events. She provided a list of alternative sites where parents can find more reliable information. (See chart.) ■

Disclosures: *Dr. Anderson disclosed that she has served as a speaker for Merck & Co., Novartis, and Sanofi Pasteur, all of which make vaccines.*

Useful Web Sites for Vaccine Info

Centers for Disease Control and Prevention vaccine safety: www.cdc.gov/vaccinesafety/index.html

CDC Vaccine Information Statements: www.cdc.gov/vaccines/pubs/vis/default.htm

National Vaccine Advisory Committee Vaccine Safety Working Group: www.hhs.gov/nvpo/nvac/vaccinesafety.html

"Vaccine Safety Research, Data Access, and Public Trust" (Washington: Institute of Medicine, 2005): www.nap.edu/catalog/11234.html

Clinical Immunization Safety Assessment: www.dcd.gov/vaccinesafety/Activities/cisa.html

Children's Hospital of Philadelphia Vaccine Education Center: www.chop.edu/service/vaccine-education-center/home.html

Source: Dr. Anderson

CDC Group on RSV Immunoprophylaxis Still Working

BY SHARON WORCESTER

FROM A MEETING OF THE CDC'S ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

ATLANTA — In the wake of a Food and Drug Administration advisory panel vote against recommending licensure of a new drug for the prevention of respiratory syncytial virus, a Centers for Disease Control and Prevention working group on RSV immunoprophylaxis will continue to develop recommendations for the use of currently available products, the group's chair said.

The new drug currently under FDA review is motavizumab (MedImmune/AstraZeneca), a humanized monoclonal antibody. The FDA advisory panel expressed concern that the drug has additional safety issues but no clear benefit over existing products on the market, Dr. Lance Chilton reported at the meeting.

Efforts will continue to develop recommendations for prophylaxis, based on available information on disease burden, safety, efficacy, and economics, said Dr. Chilton, chair of the RSV immunoprophylaxis working group and a pediatrician with the Young Children's Health Center at the University of New Mexico, Albuquerque.

RSV is the leading cause of lower respiratory tract illness in infants and young children, and currently there is no vaccine available, Dr. Chilton said, noting that efforts to develop a vaccine are ongoing, and "when it comes, it will change the face of pediatrics."

Until then, preventive treatment is available in the form of palivizumab—a safe and effective product for immunoprophylaxis, according to Dr. Chilton. However, the drug is expensive,with an estimated cost of nearly $6,700 per patient per year, and guidelines for appropriate use are needed, he said.

Dr. Chilton said the working group's efforts to develop such guidelines will include:

► A review of the epidemiology of RSV infection, including seasonality and host and environmental risk factors for severe disease.
► A review of the safety and efficacy of prophylaxis.
► An assessment of the costs and benefits of prophylaxis.
► Identification of the areas requiring further research for informing recommendations.
► Drafting of recommendations for ACIP consideration.

Up to 125,000 hospitalizations for RSV occur in the United States each year, with the highest incidence in young infants, and with a disproportionate burden among those with lung disease, heart disease, and prematurity. The FDA is currently scheduled to review the biologics licensing application for motavizumab in August. ■

Disclosures: *Dr. Chilton reported no conflicts of interest.*

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