“Model” patients and the consequences of provider responses to vaccine hesitancy

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The manner in which providers respond to parental concerns about the recommended childhood vaccination schedule is an area of increasing interest in pediatrics and medical ethics. Like many aspects of vaccination policy and practice, evaluating the reactions of providers to parental vaccine hesitancy—including the potential dismissal of such families from their practices—requires an appreciation of the twin character of vaccination as both a public health program as well as an individual preventive intervention. Accordingly, the ethics of vaccination combine many aspects of traditional medical ethics, such as respect for patient autonomy, the primacy of informed consent, and concern for the doctor-patient relationship, with the relatively newer discourse of public health ethics, one that directs particular attention to the health of populations and the pursuit of social justice. When parents are hesitant about vaccination for their children, providers may face a significant challenge reconciling their commitment to the health of those children, their respect for the perspectives of parents, and their interest in the health of their other patients and their communities. The tensions and potential conflicts among these considerations help to explain why provider responses to vaccine hesitancy have emerged as a frequent topic of discussion among practitioners, public health advocates, and ethicists alike.

The agent-based modeling approach presented by Buttenheim and colleagues makes a valuable contribution to this ongoing debate in vaccination ethics and

policy.¹ Their primary finding—that intentionally unvaccinated children will increasingly cluster in a smaller number of practices as more providers adopt stricter policies regarding compliance with recommended vaccination schedules—provides evidence of an unintended but nonetheless foreseeable consequence of such policies if adopted widely by providers in a given community. Notably, their work suggests that the anticipated reductions in the exposure of patients to unvaccinated children in providers' offices, a frequent argument made in support of policies requiring strict compliance with vaccination recommendations, are likely to be smaller than the concomitant increase in such interactions among unvaccinated children, a group at increased risk of infection, when clustered in those remaining practices that will accept them as patients. The result, therefore, may be an apparent conflict between two ethically laudable goals—providers' interest in minimizing the number of unvaccinated children in their practices and communities' interest in minimizing the overall burden of vaccine-preventable disease.²

However, as the paper's authors acknowledge, their model is a simplified representation of how vaccine-related dismissal policies are designed and implemented by providers as well as how parents may respond upon encountering them. First, there is little evidence that the strict “zero-tolerance” policies modeled by Buttenheim and colleagues are a common response of providers to requests for all alternative approaches to vaccination, no matter how minor the requested deviation from the recommended schedule. In

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cases when parents wish to delay or omit specific vaccines, substantial attention has been directed to the value of “informed refusal” documents intended to ensure that parents appreciate that such decisions may carry significant risks to the health of their children.³ Patient dismissal is more frequently discussed for potential cases in which parents hold strong views against vaccination and reject many, if not all, recommended vaccines. This is an area in which additional research on the current landscape of provider responses to vaccine hesitancy and refusal, along with their outcomes, would be of great value, better informing ethical analyses of proposed policy responses.

Second, an important argument among advocates of strict policies for compliance with vaccine recommendations is that such measures send a strong, unambiguous message to parents regarding providers’ belief in the importance of on-time, complete vaccination. In tandem with communication between providers and parents, such policies may be effective in persuading initially hesitant parents to support vaccination for their children, advocates suggest. While this possibility is not accounted for in the authors’ model, their central finding that policies that dismiss intentionally unvaccinated patients lead to the clustering of such patients in a smaller number of practices remains a valid and important consideration to include in any ethical assessment of dismissal policies.

The results of the experiments designed by Bутtenheim and colleagues, together with these additional considerations, underscore the complexity of policy-making in these areas for individual providers and for professional organizations, licensing boards, and other groups with activities or oversight related to pediatric practice. The primary question for proponents of restrictive vaccine compliance policies is whether it is an acceptable outcome that children of vaccine-hesitant parents might only have access to care from providers who are not strong advocates for vaccination, while clustering them with other unvaccinated children and thereby further increasing their risk of vaccine-preventable disease. Whether providers employ the “zero-tolerance” approach modeled

by Bутtenheim and colleagues or a more narrowly tailored program, the implementation of any dismissal policy necessarily reduces the likelihood that affected children will receive care from providers who strongly support vaccination. As a result, ongoing opportunities to educate, inform, and persuade hesitant parents would be lost, as would be the possibility that such efforts may cause these parents to change their minds. All the while, the children of these parents would remain at an increased risk of vaccine-preventable disease through no fault of their own.

Even when vaccine-related dismissal policies are structured to avoid the substantial ethical concerns associated with patient abandonment, they remain well-intended but seriously flawed efforts to promote the individual and community benefits of vaccination.² Organizations including the American Academy of Pediatrics and Centers for Disease Control and Prevention have repeatedly declined to endorse these policies,^{4,5} and the recent work of Bутtenheim and colleagues provides further reason to question the wisdom of such proposals.

Dismissal policies are unlikely to change the attitudes of the most fervent critics of childhood vaccination, those parents who are already unlikely to seek care from providers with such a clear belief in the importance of vaccines. For these parents, internet searches provide lists of local providers who are willing to cooperate with any approach to vaccine administration desired by parents, providers euphemistically described as “vaccine-friendly” by critics of contemporary vaccination policy.⁶

Instead, dismissal policies by mainstream pediatric providers would target those parents who may initially hold some doubts, concerns, or reservations about aspects of the vaccination schedule yet still wish for their child to receive care from providers who unambiguously support vaccines. Rather than turning these parents and their children away, providers should seize these opportunities, working with hesitant parents to address their concerns or confusion regarding the benefits and risks of the recommended vaccine schedule. Such an approach may place additional strains are already

overburdened providers, but it would serve the interests of the children of hesitant parents far better than policies that quite literally close the door to communication that has the clear potential to lead to the eventual vaccination of these children.

Despite substantial scholarly and popular attention to vaccine-related dismissal policies in recent years, their assessment is impeded by a lack of rigorous empirical evidence regarding the policies established by providers, the frequency with which they are applied, the responses they produce among parents, and, most importantly, their effects on childhood vaccination coverage and vaccine-preventable disease rates in communities. Evaluations of the ethical aspects of dismissal policies (and potential alternatives) would be greatly enriched by additional evidence on each of these topics beyond the limited work currently available.^{7,8} While the public health and medical ethics communities await such data, research like that of Bутtenheim and colleagues offers valuable insights, above all reminding vaccination advocates of the complexities and undesired consequences that may result from otherwise well-intended efforts to maximize the benefits of vaccination among individuals and communities.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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