

The General Practitioner's Role in COVID-19 Vaccination

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COMMENTARY

The SARS-CoV-2 virus that causes covid-19 originated in animals and transposed to people in 2019. Around 100 million people worldwide contracted COVID-19 in 2020 alone, and it claimed the lives of 2 million people. A transcendental turning point in medical history was reached with the rapid production of COVID-19 vaccinations in response to the pandemic's urgency.

The public health intervention with the most impact on preventing morbidity and mortality from infectious illnesses has been the widespread use of vaccination in recent centuries. The vast majority of people tolerate vaccinations well, and the benefits of vaccination significantly outweigh the risk of serious side events in most individuals [1]. While adverse drug responses (ADRs) can occur with vaccinations, just like with any other medical procedure [2].

Every licenced vaccination is quite successful at preventing serious COVID-19 cases. It is significant to note that, especially among individuals aged 65 and older, the risks of hospitalisations and deaths

linked to COVID-19 are significantly greater among adults who have not had a main series and are up to date on recommended COVID-19 vaccination. Current vaccines offer less protection against symptomatic infection and transmission than they do against severe disease, and their effectiveness deteriorates with time, especially against variations that are actively circulating. As new vaccines become available, it is crucial to stay up to date because of this [3,4]. Widespread immunisation is linked to a reduction in mortality and a slowed spread of the pandemic [5-8]. The COVID-19 vaccination is the best hope for limiting the spread of illness. However the negative effects of immunisation .

The community's and healthcare providers' opinions of vaccine safety are a key factor in determining vaccination rates, even if public health officials are concerned about vaccine efficacy and effectiveness since they affect disease control. For the more recent immunisations, this is more obvious [1]. Contrarily, COVID-19 is an endemic infection that will persist for generations, hence the most vulnerable should receive priority in immunisation [10].

Because their attitudes and expertise are frequently essential to encouraging adoption of a vaccine, all health care personnel play a significant role in preserving public confidence in vaccines. Clinicians need to be well aware of both common and uncommon vaccine side effects. The explanation is that through post-licensing surveillance, healthcare practitioners play a crucial and fundamental role in vaccine pharmacovigilance. Only the absence of ADRs can be used to determine the vaccine's safety [1].

Strong pharmacovigilance systems and international coordination of post-licensing surveillance are necessary for the widespread administration of vaccinations, such as the COVID-19 vaccination, in order for governments to make the best decisions and to preserve or increase public confidence in vaccines. On the other hand, general medical consultations are a reliable source of ADRs, particularly those related to vaccinations. Fundamental to understanding ADRs and preventing vaccine rejection is the GP's involvement [11]. The ongoing care that comes with getting to know patients is one of the benefits of going to a general practitioner (and the correct assessment of ADRs, avoiding the difficulties of interpreting symptoms or diseases that are not due to medications but to psychosocial effects).

Some people's fear of the vaccine is greater than their fear of the coronavirus. The focus is on the rarely occurring side effects of vaccines, despite estimates of hundreds of deaths per day from

COVID-19. There is a dearth of a culture that recognises that drugs are not risk-free and that everyone faces some level of risk. For instance, the World Health Organization detected 760 instances of polio caused by the oral polio vaccine (an attenuated virus) after giving it to 3,000 million children worldwide; yet, it is estimated that it avoided 13 million cases [12].

Yet, not everyone is vehemently opposed to vaccinations, and many may be amenable to reasoning. It's vital to remember that not everyone who has never received a vaccination is against them. In the US, 14% of adults claimed they would "absolutely not" get the vaccine as of June 2021 [13]. However a large number of people are in a "mobile field." A little over 16% of individuals want the vaccine as soon as possible, but they are delaying their own vaccination in order to observe how it affects others (for example, for their job).

However, some people are more susceptible to COVID-19 than others, including those who are 65 years of age or older, pregnant, have asthma, COPD, heart failure, chronic kidney disease, chronic liver disease, chronic neurological conditions (Parkinson's disease, multiple sclerosis, learning disability, or cerebral palsy), diabetes, sickle cell disease or splenectomy, immunosuppression (AIDS, corticosteroid treatment, or chemotherapy), or are obese.

Compliance with preventive behaviours is essential for the management of COVID-19. Different responses to preventive behaviours depend on an individual's psychological make-up and perception of danger. Perceived vulnerability is a significant influence. Although though COVID-19 is extremely contagious, the more recent varieties have milder symptoms and a lower fatality rate [14]. In general, women, older folks, those with more education, and people who have more faith in the government are more accepting of the COVID-19 vaccine [15]. For instance, 56% of men participated in a research of college students who were unwilling to get immunised [16]. Vaccination rates are also significantly lower for people with serious mental illness than for the general population.

So what should the GP do in regards to the COVID-19 vaccine? First and foremost, he or she must pay close attention to ADRs. Secondly, he or she must take advantage of his or her unique position in the health care system (continuity of care, doctor-patient relationship, patient trust in his GP, knowledge of the context) [18] to target the most vulnerable individuals and take action to persuade those who are on the fence about vaccination to change their minds. So how can one intervene to influence a patient's perception of the COVID-19 vaccination?

The following ideas are from [19–23]:

1. Listen with empathy
2. Review your biases; People are complicated and their reasons for not getting vaccinated are personal. Respect those reasons and you could have a more productive conversation.
3. See if the person is open to conversation. If not, it might be a better use of your time and energy to simply back off.
4. Be kind. The person you are trying to communicate with will immediately exclude you if you are disrespectful. Ask open questions
5. Identify the obstacle. Explore the reasons for wanting to be vaccinated. Ask if there is anything you can do to ease your load or help remove any barriers. When you don't know the answer or aren't sure how to address people's concern, offer to help find information
6. Adapt your argument to the person. Consider your specific concerns and try to address them. Do not use jargon or speak badly.
7. Choose the educational intervention (informative, assertive, persuasive, and training) according to the characteristics of the person and their known health problems.
8. Rely on people of influence for a certain target population. People who have had similar concerns but went ahead and got vaccinated are more likely to
9. persuade others than someone eager to get vaccinated. Anyone in a person's social circle could act as an influencer: teachers, coaches, religious leaders, and even friends.
10. Inform and prepare the person in relation to possible adverse effects. The public should be prepared because a subset of people may experience severe, albeit transient, side effects. Those transient reactions shouldn't deter people from getting vaccinated against a pandemic virus that kills at least one in 200 of those it infects.

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