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Do Health Care Professionals Trust Parents? A Team Ethnography of Childhood Vaccine Hesitancy from Seven European Countries

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Abstract

Social-scientific scholarship on vaccination has often stressed the importance of trust. Vaccine hesitancy has commonly been viewed as determined by the degree of trust that parents have in expert knowledge, health care authorities, and health care professionals (HCPs). Focusing primarily on parents as trustors, the bilateral nature of trust and HCPs' trust in parents have seldom been considered. This article systematically explores these commonly overlooked aspects of trust-building. Drawing on a team ethnography in seven European countries consisting of 466 hours of observations, 167 in-depth interviews with vaccine-hesitant parents, and 171 in-depth interviews with HCPs, this article explores the levels, expressions, and outcomes of trust in the vaccination context. We suggest that trustful relationships are influenced by interpersonal and generalized trust and expressed through both the affective and cognitive dimensions. We further explore interactions where HCPs' (dis)trust may mitigate vaccine hesitancy. We conclude by providing policy implications for education, campaigns, and interventions.

Keywords

distrust, ethnography, health care professionals, trust, vaccine hesitancy

"The trust relationship is reciprocal." This article purposely starts with a quote from an Italian health care professional (HCP) about doctor–parent interaction. The adjective "reciprocal" highlights the mutual nature of trust and serves as a reminder that vaccine confidence is not determined only by parental trust in HCPs, as primarily stressed in academic and public debates, but is likewise affected by the trust of HCPs in parents. Against this backdrop, this study systematically explores the latter mentioned aspect of trust-building in the context of childhood vaccine hesitancy.

The topic has attracted extensive social-scientific attention, which increased amid and after the

recent COVID-19 pandemic. Vaccine hesitancy refers to a spectrum of attitudes and can involve acceptance with concerns (Willis et al. 2024), rejection, delayed acceptance, or postponement of some or all vaccines (Dubé et al. 2021; MacDonald and SAGE Working Group on Vaccine Hesitancy 2015). The complexity of vaccine hesitancy at micro, meso, and macro levels has been discussed in volumes of scholarship focused on a variety of factors, including sociodemographic characteristics; lifestyle; values; parental knowledge; parental trust in expert knowledge, health care authorities, or HCPs; the perceived risk of vaccination or vaccine-preventable diseases; the role played by health care systems; and the politicization or mediatization of vaccination (see e.g., Dubé et al. 2013; MacDonald and SAGE Working Group on Vaccine Hesitancy 2015; Peretti-Watel et al. 2015; Wagner et al. 2024). However, the role of HCPs in vaccine hesitancy remains underresearched (Verger et al. 2022). This latter mentioned gap reflects the lack of scholarly interest in the more general areas of trust among HCPs in patients outside the context of vaccination (Sousa-Duarte, Brown, and Mendes 2020). Hence, our aim is also to contribute to the scholarship of HCPs' trust in patients.

Our study draws on existing research suggesting that "trust matters," highlighting that both interpersonal and institutional trust are key factors affecting vaccine hesitancy (Brownlie and Howson 2005; Goldenberg 2021; Hobson-West 2007; Larson et al. 2018; Peretti-Watel et al. 2019; Vuolanto et al. 2024). Epistemologically inspired by relational sociology and the needed interpretative focus to explore the processes of trust-building (Burkitt 2016; Möllering 2001), we conceive of trust as a continuously evolving part of everyday interaction between HCPs, parents, and children taking place in the broader cultural, sociopolitical, and medico-legal context (Sousa-Duarte et al. 2020).

Our work is empirically informed by extensive empirical evidence from seven European countries (Belgium, Czechia, Finland, Italy, Poland, Portugal, and the United Kingdom), carried out as a rapid multisited team ethnography in vaccination centers, hospitals, and pediatric surgeries. This is complemented by in-depth interviews with HCPs and vaccine-hesitant parents.

In the following sections, we first briefly summarize the existing literature on vaccine hesitancy and trust, with specific attention given to explorations of HCPs' trust in patients. After introducing the methodological underpinnings of this study, we present the main findings and discuss the variety of expressions, levels, and outcomes of HCPs' trust in the context of childhood vaccination. We conclude by discussing the implications of our study for future research and policy.

BACKGROUND

Health Care Professionals: From Trustees to Trustors

The focus on trust represents one of the pillars in contemporary vaccine hesitancy research developed around the consensus that "trust matters" (see e.g., Vuolanto et al. 2024). Although this assumption is reflected in the increasing scholarly interest in both interpersonal and system trust, mistrust, or distrust affecting vaccination, trust was primarily conceived as unilateral, with the primary focus on parents as the key trusting actors. Hence, previous scholarship focused on the role of parents' trust in vaccination and biomedical expert knowledge (e.g., Hobson-West 2007; Larson et al. 2018; Martinelli and Veltri 2022), science more broadly (Sturgis, Brunton-Smith, and Jackson 2021), HCPs (e.g., Brownlie and Howson 2005; Deml et al. 2022; Ebi et al. 2022; Nurmi and Jaakola 2023), or health care authorities (Goldenberg 2021; Paterson et al. 2016).

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However, only limited attention has been given to HCPs' trust in parents. This is surprising considering the general conceptualizations of trust in social theory that stress its reciprocal nature (see e.g., Gambetta 1988; Möllering 2001; Simmel 1950). Through the lens of a Goffmanian relationist perspective (Goffman [1959] 2002), trust can result as an outcome of performative action. Considering the mutual nature of trust, we hypothesize that the trust parents have in HCPs (and which potentially determines vaccine hesitancy; see e.g., Deml et al. 2022; Nurmi and Jaakola 2023; Scavarda, Cardano, and Gariglio 2025) and the trust HCPs have in parents are interdependent and mutually (re)configuring.

HCPs' trust or distrust in parents can result in a diversity of scenarios. For example, trustful communication channels between HCPs and parents can facilitate more productive conversations and foster vaccine confidence, especially considering that primary care plays a key role in triggering vaccine confidence (Callaghan et al. 2022). Specific situations can emerge in cases of vaccine-hesitant HCPs (e.g., Paterson et al. 2016) whose trust in parents can affect their vaccine hesitancy differently, contributing even to maintaining and confirming parental concerns.

Furthermore, the need to focus on trust among HCPs in parents is inspired by the broader literature focusing on medical professionalism and reflecting the necessity to consider HCPs not only as trustees but also as trustors (Brown and Calnan 2012; Douglass and Calnan 2016; Sousa-Duarte et al. 2020; Wilk and Platt 2016). Recent medical scholarship has stressed the importance of the physician's trust in patients, who feel more respected and more likely to express their trust reciprocally, accompanied by stronger discipline and involvement in the treatment process (Taylor, Nong, and Platt 2023; Thom et al. 2011; Williamson, Thompson, and Ledford 2022). At the same time, the COVID-19 pandemic exposed how structural vulnerabilities and racialized inequalities shape trust in health care (Thakur et al. 2020). Recent studies highlight patterns of epistemic and physical harm, suggesting that racism may lead to violations of parents' dignity and the silencing of the concerns held by vaccine-hesitant parents (Hamed et al. 2020). Trust can be shaped by structural factors imprinted into interpersonal encounters, particularly when parents feel misrecognized, disbelieved, or deemed untrustworthy during interactions with health care providers (Decoteau and Sweet 2024).

Several accounts have focused on nuances in the approach of HCPs toward parents, implying, rather than explicitly articulating, trust or distrust. Instead of focusing primarily on trust, these studies explored various aspects of clinical practice and communication among HCPs to analyze vaccine confidence or vaccine hesitancy. Patient perception of HCP trust was viewed as constitutive of patient or parental trust, reinforced by the disclosure of compassion and empathy (Greenberg, Dubé, and Driedger 2017) or by the manifestation of honesty, transparency, and trustworthiness (Brownlie and Howson 2005; Greenberg et al. 2017).

Trust is intrinsically and instrumentally significant for the meaningfulness of patient–provider relations and for the effectiveness of therapeutic encounters (Deml et al. 2022; Lermytte, Bracke, and Ceuterick 2024). Moreover, it is continuously reconfigured during these encounters (Calnan and Rowe 2006). Furthermore, the administration of partial doses or delays in vaccination can be used by some doctors to maintain a trustful relationship with patients and parents (e.g., Paterson et al. 2016).

On the other hand, distrust of HCPs can potentially trigger vaccine hesitancy, particularly in cases where HCPs disregard parental concerns or use stereotypical or biased classifications, categorization, or labeling (Deml et al. 2020). Some parents even anticipate the posture of HCPs, linking medical authority with a low capacity to comprehend parental visions of "good," protective, and responsible parenting. These defensive expectations could further weaken mutual trust between HCPs and parents and help trigger vaccine hesitancy (see e.g., Carrion 2018; Paul et al. 2024).

General observations on trust in the health care context suggested that trust has both cognitive and affective components (Gilson 2003). HCPs' trust in parents is thus expressed through emotions and cognitive detachment linked with clinical knowledge (Austen 2016). Considering the construction of the medical professional identity, the relevance of social components of trust beyond both the cognitive and affective dimensions needs to be considered. Inspired by the sociology of professions, we furthermore assume that the medical knowledge imprinted into their cognitive detachment and their professional values, norms, and authority (see Evetts 2011) altogether nourish HCPs' emotions and determine the nature of interactions between HCPs and parents.

Previous accounts suggested that HCPs' trust can be influenced by several factors, including previous interactions with patients, patient compliance with the HCPs' recommendations, the transparency

of their behavior, or consideration of broader patient characteristics (Błaszyk and Kroemeke 2024). This trust could be expressed in relation to the cognitive capacities of patients but also to their sociodemographic characteristics or more specifically, their race and ethnicity (Moskowitz et al. 2011). Interactions between patients and HCPs have specific histories and sets of (mis)representations that affect the meanings attributed by both groups to each other (Scambler and Britten 2001). These histories can be influenced by HCPs' experiences with diverse patients and by stories shared in professional health care communities.

Against this backdrop, our aim is to explore trust-building as a reciprocal process, highlighting the mutual nature of interactions between parents and HCPs. More specifically, the objective is to explore the main dimensions of HCPs' trust in parents, the levels and expressions of trust, and their impact, with a specific focus given to vaccine hesitancy.

DATA AND METHODS

This study was based on a rapid multisited team ethnography carried out in seven European countries: Belgium, Czechia, Finland, Italy, Poland, Portugal, and the United Kingdom (Cardano et al. 2023). A rapid ethnography, which differs from traditional ethnography based on long-term engagement with a clearly confined field and instead consists of short periods of high-intensity fieldwork (Vindrola-Padros 2021), allowed us to generate data in the context of the broader cross-country project Addressing Vaccine Hesitancy in Europe (VAX-TRUST), carried out under the challenging circumstances of the COVID-19 pandemic. The selected countries have different organizations and legislative vaccination regulations, with compulsory vaccination in Italy, Poland, and Czechia; partial vaccination (with polio vaccine compulsory only) in Belgium; and recommended vaccinations in the United Kingdom, Finland, and Portugal. Although international in scope and drawing on multiple cases, our analysis was not designed as a systematic comparative study. Rather, it was primarily exploratory, aiming to identify key patterns of bilateral trust-building and to capture the complexity of this relatively unexplored topic. The main objective was to explore shared patterns and differences as they emerged inductively from the data, in line with the interpretive and constructivist traditions of the relational approach. References to national settings are provided for explanatory purposes to better locate and explain our findings in the diversity of administrative, cultural, organizational, and legislative contexts.

The study drew on extensive empirical evidence generated from 466 hours of observations, 167 in-depth interviews with vaccine-hesitant parents, and 171 in-depth interviews with HCPs, including pediatricians, general practitioners, nurses, midwives, and doulas, reflecting the diversity of professional groups involved in the administration of vaccination across different countries and the diversity of vaccine programs and schedules. Although the primary focus was on vaccine-hesitant parents, the voices and attitudes of nonhesitant parents were also captured thanks to the observations. The observations of interactions between HCPs, parents, and children reflected some epistemological underpinnings of relational sociology and the need to understand trust as being built reciprocally. This involved the necessity to focus on the intersubjective "reality" as constituted in the reciprocal interaction between the trustor and the trustee (Möllering 2001). Ethnographic observations at vaccination centers and surgeries enhanced an analysis of the bilateral nature of trust and allowed us to explore the interplay between HCPs and parents, examine how HCPs' lack of trust could trigger or reinforce hesitancy among parents, and analyze the perspective of both groups of actors. Whereas the interviews with vaccine-hesitant parents allowed us to understand the reasons for their doubts, the interviews with HCPs and observations allowed us to explain processes and mechanisms underlying vaccine confidence.

Moreover, the observations allowed us to explore the performative nature of trust and disentangle the meanings attributed to the HCPs' social performance as part of their clinical practice, enhancing the comparison of frontstage interactions between parents and HCPs and background comments made by HCPs before or after these interactions during interviews and observations.

The bilateral nature of trust was enhanced thanks to ethnographic observations at vaccination centers and surgeries that allowed us to explore the interplay between HCPs and parents, examine how HCPs' lack of trust could trigger or reinforce hesitancy among parents, and analyze the perspective of both groups of actors. Whereas the interviews with vaccine-hesitant parents allowed us to understand the reasons for their doubts, the interviews with HCPs and observations allowed us to explain processes and mechanisms underlying vaccine confidence.

The overall focus on HCPs addressed the relatively scarce vaccine hesitancy research focusing systematically on HCPs (Verger et al. 2022). All recruited HCPs were directly involved in communication or practices concerning vaccination, and the aim was to maximize the heterogeneity of HCPs in

terms of age and gender while reflecting the local demographic specificities of health care professions. Several recruitment strategies were used, including advice from local professional associations, desk research, and parental recommendations. Snowball sampling was further employed to enlarge the sample. The sample included several vaccine-hesitant HCPs, including those who were vaccine-benevolent and open to an individualized vaccination schedule and those who were completely opposed to vaccination. These strategies allowed us to mitigate the risk of selection bias, which still needs to be taken into consideration; primarily, HCPs interested in proactively dealing with the topic of vaccine hesitancy reacted to our queries for interviews, and not all vaccine-cautious individuals agreed to be interviewed.

As regards the interviews with parents, the sampling strategy reflected that they represent a vulnerable and hidden population. A combination of tools was employed to ensure sampling heterogeneity, particularly regarding the participation of parents whose hesitancy could be situated across the whole spectrum of vaccine hesitancy attitudes and the diversity of lifestyles and sociodemographic characteristics of participants. Moreover, we included at least two fieldwork sites from different neighborhoods in all the countries. We employed convenience sampling based on printed advertisements and online communications in relevant alternative parenting groups on Facebook, Telegram, and WhatsApp. In the United Kingdom, a research recruitment platform was used. Observations further served to recruit vaccine-hesitant parents. This strategy allowed us to include not only those who are collectively organized, involved in protests, campaigning, and often active in the social and mainstream media but also those whose hesitant attitudes would have remained publicly unknown. This approach further helped to mitigate the selection bias inevitably faced by any type of sampling; we faced several refusals to participate in the project due to the fear of stigmatization and external surveillance, especially in countries with compulsory vaccination or due to ideological disagreement with the research project. In general, given the vulnerability of the population, recruitment strategies and interactions with participants illustrated the ethical principles and reflected the need to maintain a trustful relationship with respondents (Hilário et al. 2023).

The data analysis and coding process took place in several steps and involved the development of an NVivo codebook, guided by our evolving theoretical framework and the collective examination of evidence that prompted our abductive inferences (see Cardano 2020; Tavory and Timmermans 2014). Although the focus on the interactions between HCPs and parents was part of the original framework, the importance of the nexus between interactions and reciprocal trust emerged only during the analytical process. By selectively focusing on data related to interaction, we have further developed the main analytical categories that helped us to disentangle the nuances and complexity of HCPs' trust and distrust, their associations with the trust of parents, and their impact on vaccine hesitancy (for more details, see Appendix 1 in the online version of the article). Several online discussions took place among the project team members, and more selective coding approaches were used to increase analytical sensitivity toward the reflected trust of HCPs during the main stages of analysis. Interview quotes were translated from national languages to English by the authors of this study.

RESULTS

Our cross-national study strongly shows that "trust matters" in childhood vaccination. In the following analytical account, we suggest that the analyses concerning the (dis)trust *of* parents need to be coupled with a focus on (dis)trust *in* parents. In other words, HCPs' trust in parents is an important prerequisite for parental trust in HCPs and vaccine confidence or even medicine more broadly, considering that HCPs act as "access points" to the system of expert biomedical knowledge (Giddens 1991). In the next paragraphs, we discuss the levels of (dis) trust in parents and children, the expressions of (dis) trust, and finally, the impact of (dis)trust on vaccine hesitancy.

Levels of Trust

Trust in parents is constructed at two interconnected levels: interpersonal and generalized. More specifically, interpersonal trust is built as part of personal encounters between HCPs and parents. Generalized trust is developed in relation to socioeconomic status, demographic characteristics, lifestyles, norms, values, or the ethnicity of parents.

Interviews and observations suggest that the development of interpersonal trust draws on the history of interactions and shared experiences, (non)compliance with HCPs' recommendations, (a lack of) parental transparency in communication, or (a lack of) honesty related to the administration of vaccines and to care unrelated to vaccination. This trust in parental commitment is primarily affective,

representing a fundamental basis for interactions between parents and HCPs and an important source of emotional empathy. On the other hand, a breach of confidentiality and declining trust in parents can further trigger vaccine hesitancy or even contribute to vaccine refusal. This is well illustrated by the following story told by a Czech parent:

> She [the HCP] told me that she doesn't see any reason why the vaccination should be postponed [the mother reported that her son experienced vomiting, high fever, and a food allergy after the first hexavalent vaccine dose], that it is okay like this, that this is how he does it with all the kids, and there was never a problem. At the same time, we kind of saw that it was a problem, and somehow, we didn't want to be pushed into it. I am a health care professional, so I have some faith in the vaccination, and I had trust in the doctor. But the first experience undermined my trust a lot. And, following this, I have a large amount of distrust in her, in her procedures. (Interview, Czechia, Parent 17)

The sudden rupture in the relationship and the eroded communication channels, described here as a loss of "trust in the doctor" in reaction to the lack of trust embedded in the paternalistic approach of the pediatricians, reflect the importance of interpersonal trust for vaccination encounters. The importance of interpersonal trust related to somewhat unique shared histories is particularly relevant in countries where vaccinations are administered and negotiated as part of a continuous relationship between HCPs, parents, and their children. When developing their trust in parents, HCPs consider the social role of parents, their socioeconomic status, or demographic characteristics. Moreover, norms, values, and lifestyle preferences represent other significant aspects underpinning generalized trust and determine the construction of trust between HCPs and parents. In other words, interpersonal, horizontal trust cannot be disentangled from more vertical, generalized trust because both are intercorrelated and interact in a complex and multidimensional "web" of trust (Attwell et al. 2017; Meyer et al. 2008).

First, generalized trust in the context of childhood vaccination is expressed as trust in the social role of parents, intertwined with the expectation that the parents always act in the best interest of their children (see also Wang, Baras, and Buttenheim 2015). This generalized trust was commonly reflected in HCPs' references to "good mums" or "good parents." HCPs frequently demonstrated that they trust parents' willingness to do "their best for their children" and recognized parents' experiential expertise and "intuition," as illustrated by the following quote:

> You [as a parent] decide what is best for your child. And you can make the best decision about that. Just make sure you are well informed. I'm never going to force you [to vaccinate], and you want the best for your child. And I often say, "That doesn't make you a bad parent." (Interview, Belgium, HCP 26)

These comments reflect the expressions of generalized trust in a broader social group of nonspecified parents. Compared to interpersonal trust, generalized trust is more abstract and relies on imagined representations of groups of parents and, in a sense, of unknown others. Affective trust in parents' willingness to act in the best interest of their children represents an important base for a trustful relationship between HCPs and parents. However, it is not inevitably accompanied by trust that parents are always able to make cognitively well-informed decisions that reflect the best interests of the child.

The need to contextualize claims of good parenting was acknowledged by some HCPs, who argued that the term "a good parent" is a social construction with diverse meanings. This is illustrated by the following observation made by an HCP in the United Kingdom concerning the notion of "good mums":

> The people in the poverty areas want to look like good mums so they do as they're told. The people in the affluent areas want to look like good mums so they do their own research. It's just very different, isn't it? (Interview, United Kingdom, HCP 12)

This observation made by an HCP illustrates that their trust is affected by how they consider the social milieu of parents; this was also revealed in several other interviews and observations. These alleged contextual differences lead us to discuss the second point related to generalized trust—that the doctor–parent relationships can be determined by the "imagined" socioeconomic status of parents—and the alleged implications this status might have on health-related behavior. This form of reasoning was similarly demonstrated by an anecdotal proto-sociological point made by a nurse from Poland who highlighted how the place of residence might matter

while explaining the lower vaccination rates in a village:

> There are plenty of guesthouses here, and mothers have plenty of time, and they surf the internet. And . . . there are [web]sites with those stupid things. Those who have guesthouses are rich, but without education. . . . Those rich people from guesthouses think they are clever and don't need education. (Fieldnotes, Poland, Site 4)

Third, the nationality or ethnicity of parents represents other factors affecting HCPs' generalized trust or distrust. Some refugee parents were viewed through more critical and distrustful lenses, either as someone who misuses the quality and accessibility of health care in the host country or, more generally, as citizens with lower trust in authorities or of a country with some alleged past problems with vaccination programs. Refugee parents newly arrived from war zones were therefore viewed as potentially problematic:

> I collaborate with a Ukrainian doctor who understands them [Ukrainian parents] better and who says they are lying when we ask if they have been vaccinated, and they show some papers or photo documentation. Quite often, allegedly, I don't want to quantify it, but certainly, in more than a quarter of the cases, the colleague [from Ukraine] who helped me, either hinted or directly said that they were lying. (Interview, Czechia, HCP 18)

This quote shows how stereotyping, stigma, and the resulting generalized suspicion of HCPs might guide relations with patients (see also Lin 2022). This distrust extended by HCPs, we argue, might spin the wheel of reciprocal distrust initiated by stereotypes. Migrant status thus functioned as a marker of "otherness," shaping interactions. However, as the fieldnotes showed, considerations of nationality can also result in sympathetic approaches toward parents. This happened with Ukrainian migrants in Czechia or Poland amid the war in Ukraine and was motivated by a "moral duty" toward the war refugees (Fieldnotes, Czechia, Pediatric Surgery 3).

Fourth, HCPs' trust in parents is further built by consideration of the norms, values, and opinions of parents. Lifestyle cues often served as a mechanism that triggered the distrust of pediatricians; for example, Waldorf education, artistic professions, and education in the humanities were occasionally mentioned as markers of alternative lifestyles, linked with preferences for complementary or alternative medicine and with vaccine hesitancy.

Generalized trust is related to not only lifestyle norms and values but also to professional norms and values. From the perspective of professional authority, HCPs tended to express their cognitive distrust and understood vaccine hesitancy as a cognitive deficit. This was well illustrated by a claim made by an HCP from Belgium who referred to nonvaccination as something incomprehensible to "our [professional] groups":

> The point of view of not vaccinating a child, that vaccines are dangerous, or not administering vaccines for one reason or another. . . . For our groups, that is—well, unacceptable is a difficult word, but it is incomprehensible. (Interview, Belgium, HCP 20)

Finally, national contexts operated as important contextual factors influencing generalized trust. On the one hand, mandatory vaccination left a relatively narrow space for the expression of trust, being sometimes praised for not allowing parents enough space to express free will, as if HCPs would not trust parents' capacities to make sufficiently qualified decisions. On the other hand, some HCPs pointed out that such an obstruction of free choice may bring tensions to the trust relationship due to broader institutional constraints. An intriguing relationship between mandatory vaccines and trust emerged in the sample of Italian HCPs. Several HCPs directly involved in the vaccination practices viewed compulsory vaccination as, "sadly," a necessary consequence that reflects the impossibility of trusting parents for either moral or cognitive reasons. The moral argumentation involves references to public health and collective immunity, stressing that the mandatory system allows consideration for others and acknowledges that "people will do what they want and don't think about others; they think only about themselves" (Interview, Italy, HCP 20). The cognitive arguments target the parents' incapacity to choose the best for their offspring.

In other words, health systems serve to demarcate or symbolically confirm the cognitive or affective (dis)trust of HCPs in parents. In everyday pediatric practice, this demarcation was further evident through the use of informed consent, which allowed HCPs to mitigate their liability concerns and protect themselves legally. At the same time, it left some space to maintain the autonomy of parents and, under the guise of formal obligations,

could serve HCPs to strengthen trustful relationships with parents.

Expression of (Dis)Trust in Clinical Practice

Our analysis of the interactions between HCPs, parents, and their children suggests that trust and distrust are expressed through a myriad of different ways, stemming from a compassionate, trustful approach to distrustful downsizing of parents' perspectives or indifference toward them.

The affective basis for interpersonal trust was fostered by some HCPs acting as "confidants" and demonstrating emotional empathy. The constellations of reciprocal trust were triggered by HCPs who stressed their nonclinical qualities to contextualize and humanize any aspects of their medical authority. As part of their everyday clinical practice, HCPs stressed their parental roles by introducing their claims with sayings such as "myself as a mother" and referring to their own parental experience to demonstrate that they "know what they [the parents] feel." Various HCPs repetitively demonstrated that they could look at the discussions about vaccination through parental, nonexpert lenses. These references helped to establish a mutually shared, trustful ground for interaction, working as a reminder that all actors are aware and have a common understanding of emotional parental commitment. Listening to the stories of parents, rewarding their lay knowledge, and creating a bridge between lay and expert knowledge further enhanced trust between HCPs and parents. The following excerpt from the fieldnotes illustrates how HCPs act as confidants, in this case, being open to the postponement of vaccination despite an approaching "journey to Africa." Observations suggested that a less paternalistic position made the parents feel at ease:

> Pediatrician: "I don't know what I would do if it was my child. Probably, I wouldn't vaccinate. But here I am as a medical authority, and I have to take a wider perspective. Above all, the journey is riskier, the plane. . . . That's on the scales for vaccinations," says the pediatrician. The mother replies: "We will consider it." (Fieldnotes, Czechia, Site 1)

The trustful "confidant" lenses were further strengthened by the capacity of HCPs to give voice to hesitant parents and react to their accounts without providing them with statistical data or scientific notions. The attitude to avoid abstract scientific claims is well illustrated by the strategies used by one interviewed medical doctor to calm down parents who were afraid of specific adverse effects from vaccines. The doctor stressed how she left aside the correlation between the vaccine and the supposed damage, without referring to the specialized jargon:

> They may have been frightened by a suspected adverse effect. They report it to you, and you try to explain the inconsistency of the correlation, then . . . they tend not to cause problems. [. . .] If you have a calm approach . . . it happens . . . you could decide to have them all [the vaccines]. (Interview, Italy, HCP 2)

The role of HCPs' trust concerning vaccine hesitancy emerges in the broader context of transformed doctor–patient relationships, engaged patients (see Timmermans 2020), and parents, as suggested in a remark by an HCP from Flanders who commented on the more frequent emergence of the comprehensive approach toward vaccine hesitancy given that parents "have become empowered" (Hobson-West 2007):

> People have become more empowered. And that is a good thing. They do not simply accept everything, like my parents did in the past. . . . People are different now, they have more information. It is up to us to take that into account. (Interview, Belgium, HCP 28)

The recognition that parents would like to have their say has not been exclusively viewed as a matter of fact but, in some instances, also as a matter of concern, as an aspect challenging professional authority. HCP distrust in parents was expressed through intuitive and nonsystematic categorization, classification, and profiling of parents, commonly accompanied by labeling, othering, stereotyping, or stigmatization.

Various expressions of HCP distrust in parents emerged not only during interviews but also as part of observations, including situations without the presence of parents, when some HCPs critically commented on the parents, judged them, or classified them as "bad parents," sometimes conflating affective trust with trust in cognitive capacities. This is well illustrated by the following fieldnote suggesting how a home birth was perceived as

problematic and related to the "anti-vaccination" stance in one of the observed sites:

> Prior to the visit of one family, the doctors anticipated the arrival of "a problematic family" who refused vaccination. "This will be anti-vax and homebirth, Jesus," further commenting that "with home births, there is a problem, definitely." (Fieldnote, Czechia, Site 2)

The HCPs who classify parents as such made assumptions about the knowledge deficits of parents. They tended to believe that parents' understanding is too limited to make such decisions, as implied by the following quote:

> Why would you give people a choice about something they know nothing about? If my car technician said, "Put petrol in there," then I would never fill up my tank with diesel. Only when it comes to medicine do people have the arrogance to say, "I will decide about that now." (Interview, Belgium, HCP 29)

To sum up, HCPs express their trust or distrust in a myriad of ways and in relation to both cognitive and affective aspects. The language and categorizations of patients can play a significant role in these processes, sometimes resulting in their stigmatization but also other outcomes, further discussed in the next section.

Outcomes of (Dis)Trust

The trust of HCPs in parents can have different interconnected outcomes. First, it can affect the way in which HCPs interact with parents and their children. Second, considering the mutual nature of trust, HCPs' trust can affect parents' trust in HCPs and third, their vaccine confidence. Trust in parents can reciprocally trigger trust in HCPs and consequently, mitigate or deepen vaccine hesitancy. Finally, the relationships of trust built through interaction about vaccinations can have an impact on the interaction HCPs have with children and parents outside of the vaccination context.

As anticipated, trust or distrust affects the ways in which HCPs approach parents. As documented in the previous sections, distrust expressed through categorization and labeling is embedded in the structural pressures of everyday professional work and affects the approach HCPs take with different parents. HCPs commonly admit that they work under significant time pressure and seek to provide the best care possible. They labeled some patients as "lost causes," with whom long "discussions that go nowhere" are deserving of avoidance.

In some national contexts, labeling and distrust affect not only the decision on how to approach specific parents but also the decision as to whether to provide pediatric care to their children. This is relevant in the Czech context, where vaccination is ensured by pediatricians. Therefore, any discussion about vaccination inevitably affects the long-term relationship between HCPs, parents, and children. Parents in Czechia can choose their child's pediatrician, and the pediatric approach toward vaccination is one of the crucial factors determining the selection of pediatricians. However, the selection process for pediatricians is bilateral; pediatricians also have a say in the selection of children, occasionally screening parental attitudes toward medicine, including vaccination. What a priori stereotypical and labeling approach could mean to a parent is well demonstrated by the following quote:

> I told her [pediatrician] that I would give birth in [Town x], and she then told me that she would not register me because I would not want a vaccination and that I should look for another pediatrician. And when I told her that I hadn't thought about vaccination at all yet and that I was planning to vaccinate, she told me, "Yes, that's what you're saying now, but then you won't want to vaccinate." . . . I felt like I was being appallingly placed in some kind of category as a crazy alternative mother. . . . And that was the beginning of it [thinking about vaccination]. It made me hesitant, like, what was actually happening there. (Interview, Czechia, Parent 22)

More specifically, banalizing, ignoring, or downplaying the concerns of parents contributed to the decrease in trust among parents, as is also demonstrated by the following quote made by a Polish parent:

> The physicians did not inform us as well. There was no room for a decision; it was just outright mocking our concerns. It's unthinkable to me. I'm saying, at the moment, it's very bad because doctors have forgotten the Hippocratic Oath. It's really not—it's really very rare at the moment that the doctor himself proposes something to

> the parents and lets them decide. Abroad it's different; for example, it is the norm that they get a whole list of recommendations: what, where, to whom, who's going to help you with autism or with Down's. (Interview, Poland, Parent 24).

The reference to the situation "abroad," where more attention is given to parental concerns, suggests a parental demand for a less paternalistic approach from HCPs. Some HCPs reflected on the communication practices used in the professional community and discussed the impact they can have on the trust of parents. This is exemplified by an HCP from Belgium who argued that labeling "mostly drives people away" (Interview, Belgium, HCP 13). Another HCP reflected on the risk of labeling performed within the professional community:

> Yes, I had it last week with one child who was only vaccinated for polio. The parents had refused the other vaccinations. And it was clearly labeled on the paperwork: "anti-vaxxer." I thought, well, I was really struggling with that. (Interview, Belgium, HCP 22)

Other HCPs similarly stressed the need to take parental concerns seriously. They highlighted the importance of a compassionate approach and the need to avoid an "imposing" disposition, keeping in mind that this triggered trust in HCPs and, thanks to expressions of trust by HCPs, has the potential to further affect vaccine hesitancy:

> [T]hey [the hesitant parents] often feel resistance because society doesn't take them seriously or labels them as overly cautious or alternative. By making it clear that it doesn't bother me, showing them that they can have their opinion . . . , I always mention, "I've seen a lot of shifts, but the core remains that vaccination is important. However, it's possible that different perspectives may emerge later, and you might turn out to be right." (Interview, Belgium, HCP 23)

That HCPs' openness, "honesty," and "correct dialogue" could contribute to mitigating vaccine hesitancy was similarly illustrated by the comment made by a parent from Italy who praised the "honest" approach of a cardiologist in comparison to the "vaccination doctor":

> Our son Andreas has a very rare heart disease, and the answer I always got from the cardiologist was, to be honest: "Madam, there are no statistics, there are no figures to answer your question." And this stuff, paradoxically, is reassuring because you know that you are dealing with a person who wants the best for your child as much as you do, who will do everything possible, who is not the Eternal Father and cannot guarantee you anything, but it gives you confidence because there is a proper dialogue. (Interview, Italy, Parent 19)

In addition to mitigating vaccine hesitancy, different degrees of trust or distrust can contribute to maintaining the existing vaccine hesitancy status quo, perhaps even strengthening it. The absence of bilateral trust triggered by HCPs' "aggressiveness" is well illustrated in a point made by a parent from Finland:

> Well, they felt very aggressive, condescending, and at the same time, like there wasn't even an attempt or any desire to try to understand my motives or believe that I was somehow just trying to make the best guess as to what is best for the child. . . . There is no avenue for that. It mainly just decreased trust and took our relationship in a worse direction. (Interview, Finland, Parent 11)

This was not limited to indifference toward parental concerns. Labeling also triggered vaccine hesitancy and refusal, as reflected in a comment made by another parent from Finland. The following quote testifies to the problematic existence of "a wall" built primarily across cognitive lines. The parental observation suggests that parental concerns are not only somewhat downplayed but going a step further—parents are labeled as "conspiracy theorists":

> There is some kind of a wall there that prevents us from discussing things because they do not want to discuss [them]. If I send them a study, they won't even read it. It seems like, that no matter what research I show, I'm always just a conspiracy theorist just because, because I read research. . . . The doctor says blah, blah, there are a lot of these claims. They just don't want to hear that it could have come from the vaccine. If you think about this topic, the fact that they are not telling the truth increases the hesitation. (Interview, Finland, Parent 1)

However, in some occasional cases, trustful relationships, notably when interacting with

vaccine-hesitant or benevolent HCPs, also triggered (or reinforced) the vaccine hesitancy of parents. The "benevolent" approaches of one HCP at one observed site suggested that the possibility of postponing vaccination and individualized vaccination schedule plans was more frequently made use of thanks to the trustful relationship with the pediatrician (fieldnotes, Czechia, Site 1).

Finally, discussions about vaccinations can affect broader, nonvaccination-related care provided by HCPs. In particular, HCPs who secure vaccination and are involved in continuous care appreciate the necessity of maintaining trustful relationships with parents for the purpose of unexpected nonvaccination events. Furthermore, they aim to prevent children's fears and anxieties. The coupling of interviews and observations or the reflexive comments made by HCPs during interviews suggest that distrust might be purposively hidden, in Goffmanian terms (Goffman [1959] 2002), in backstage, with interactions between HCPs, parents, and children differing in the frontstage. As part of everyday clinical practice, the distrust of HCPs might be contained; the trust of HCPs is performed rather than experienced and takes place as if the relationship was trustful. As some HCPs pointed out, although they might have doubts about parents' lay immunization theories, they still behave in a compassionate way. "Good relationships" are vital to some HCPs' ability to provide effective care when faced with unexpected and urgent pediatric care, including, for example, in cases of infection or injury.

On the other hand, not all doctors have the performative capacity to hide their emotions and maintain trustful relationships with parents, as well illustrated by a comment made by a Finnish vaccine-hesitant parent: "My HCP couldn't really hide that there was anger just under the surface in their attitude, so that . . . that just can't be a starting point for any kind of conversation" (interview, Finland, Parent 11).

DISCUSSION

This study documents that HCPs' trust in parents can play an important role in the context of childhood vaccination. Following previous literature developed primarily out of the vaccination context (see e.g., Brown and Calnan 2012; Douglass and Calnan 2016; Sousa-Duarte et al. 2020; Wilk and Platt 2016), HCPs are studied not only as trustees but also as trustors. Therefore, in this article, we primarily focus on HCPs and their experiences with vaccination. This helps us to enrich the prevalent unilateral perspective, also highlighted in the SAGE Working Group on Vaccine Hesitancy model (MacDonald and SAGE Working Group on Vaccine Hesitancy 2015). The two-way understanding of trust, drawing on the tradition of relational sociology (Burkitt 2016; Möllering 2001), allows us to speak about not only trust *in* (something/someone) but also trust *between* social actors. This stress on HCPs' trust is particularly timely considering the role of HCPs as "access points" to the system of expert knowledge (Giddens 1991) and given the importance of trust in the health care system in the vaccination context (Goldenberg 2021; Lamot, Kerman, and Kirbiš 2024; Larson et al. 2018).

This cross-national study provides several contributions to existing literature: HCPs' trust is expressed in a myriad of ways; it is developed at two interconnected levels, interpersonal and generalized trust. Moreover, we empirically attest that (dis)trust is expressed through both the affective and cognitive dimensions. Emphasizing their interconnections aligns with previous studies on interactions between HCPs and parents with respect to vaccination, including those that still attributed analytical primacy to HCPs as trustees (Deml et al. 2022; Scavarda et al. 2025), and with broader research on trust (Burkitt 2016; Gilson 2003). Furthermore, we pointed out the necessity of considering performative trust because trust can be lived and experienced but also performed. The purposive manifestations of trust, although not rooted in trustful feelings, served as a tool to enhance the effectiveness of care. We also pointed out that although HCPs' trust in parents can prevent or mitigate vaccine hesitancy, it can also trigger it. Finally, we stressed that mutual trust built around vaccination is, on the one hand, determined by pediatric care, but on the other hand, vaccination may determine pediatric care and affect the more general relationship between HCPs, parents, and children. Hence, amid the broader transformed doctor–patient relationship (Timmermans 2020; Wilk and Platt 2016), listening rather than downplaying patients' concerns is an important vehicle for the development of trustful relationships, which is of high relevance in the context of preventive measures and urgent health problems.

Conversely, HCPs' distrust can be associated with distrust of parents and, therefore, trigger vaccine hesitancy, resistance, or defensive behavior in parents. Stereotyping and othering parents and their inappropriate gatekeeping based on alleged and anticipated noncompliance represent important

ethical implications for our understanding of clinical practices. Some of these conclusions are in line with previous scholarship that suggested that mutual distrust can be triggered by the excessive imposition of medical authority and is associated with understanding gaps between HCPs and parents (Paul et al. 2024). We have documented that interpersonal distrust is affected by generalized distrust that reflects broader social processes and structural determinants, some of them accelerated amid the COVID-19 pandemic, notably those related to the polarization of vaccination debates that could undermine support for other immunizations (Motta 2023). Other macro-social aspects include systematic racism and exclusion reproduced in health care systems and HCPs' behavior (see e.g., Decoteau and Sweet 2024; Hamed et al. 2020; Pattillo et al. 2023).

Moreover, trust is not only mutual but also mutable. Our empirical observation reflects the broader assumption developed in the context of relational sociology, highlighting that trust emerges through cognitive and emotional engagement with others and is transformed across time and space (Burkitt 2016). This observation has implications for our understanding of vaccine hesitancy, being context-dependent and mutable in time and open to transformations due to personal experiences, interactions with HPCs and the health care system, and broader societal transformations. This is why our study could inspire further contextually sensitive explorations of vaccine confidence or vaccine hesitancy trajectories (see also Paul et al 2024; Wachinger et al. 2024).

Although this article primarily focused on the trust developed between HCPs and parents, the network of trust in the context of childhood vaccination is even more complex. Beyond the focus on these specific interpersonal relationships, further research could engage with the related trust of providers in the parental community more broadly. Moreover, more emphasis could be given to the primarily triadic nature of trust, which—along with parents and HCPs—first and foremost involves children.

Furthermore, a variety of HCPs involved in developing trust, such as general practitioners, pediatricians, nurses, doulas, and midwives, should be considered in different organizational and regulatory contexts. Our explorative observations suggest that there are differences and similarities among professions not only across countries but also within them. Future research could delve deeper into trust-building in specific geographic contexts, considering the role of health care and vaccination systems. Lastly, the link between vaccination and continuity of care is another key element of mutual trust worth exploring.

To conclude, our scholarly observations have some implications for HCP education and policy, especially considering that the importance of trustful relationships in health care systems remains at the margins of policymaking (Calnan and Rowe 2006; Gilson 2006). Medical education can highlight the importance of HCP trust for vaccine hesitancy, and the recent stress on emotional empathy in learning curricula (Jenkins et al. 2021; Vinson and Underman 2020) could play an important role in this regard. Empirically informed campaigns and intervention activities about the complexities of vaccine hesitancy and communication training (see e.g., Carrion 2018; Emerson, Hobson-West, and Anderson 2023) focusing on factors that mitigate the distrust of parents could contribute to developing more compassionate and bilaterally trustful relationships between HCPs and parents and, more generally, encourage reflexive awareness among HCPs.

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SUPPLEMENTAL MATERIAL

Appendix 1 is available in the online version of the article.

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