

“Philosophy begins in wonder. And at the end when philosophic thought has done its best the wonder remains.”

— Alfred North Whitehead

Hot Topic

Vaccination

Nearly everyone working in healthcare (or living within the United States) is aware of the increasing number of parents refusing to vaccinate their children. These families, known as “anti-vaxxers,” have been the focus of public debates, discussions, and frustrations. Many reasons are given why these families refuse vaccinations, from misinformation regarding their causing autism, to mistrust as to the value of the vaccines, to a libertarian argument for personal freedom and choice. Whatever the reason for refusal, the question for medical providers remains the same: How do you properly and effectively engage with these families?

Evidence-based research establishes the benefits and promotion of vaccinations based on principles of distributive justice and values that inure to common good ([Fredrickson, Davis, & Bocchini](#)) ([Armstrong, 2007](#)). That point established, it’s important to understand why parents may not want to have their children vaccinated. One of the most valuable benefits of health ethics is learning to take in additional perspectives and to see topics from different points of view. In relation to this issue, Brian Primack of UPM put it this way in “If we dismiss anybody who has an opposing view, we’re giving up an opportunity to understand them and come to a common ground.” ([Primack](#))

Popular beliefs have traditionally focused on the fear and the claim among many “anti-vaxxers” that having children vaccinated leads to those children developing autism. [New research](#) points to a broader array of concerns with topics and people clustered around four sub-groups of trust, alternatives, safety, and conspiracy. Historically, the fear and claim originated in a now debunked academic study that made the correlation between vaccines and autism published and since retracted in [The Lancet - Retracted](#)). Despite the original study being thoroughly disproven, along with a more recent (2018) large study showing no correlation ([Dudley et al. 2018](#)), the belief and fear remains within a cohort of families who distrust health providers and seek alternatives. Another important consideration, is that a driver of the fear/belief phenomena is its connection to belief in conspiracy theories, which are universal, social, emotional and consequential, impacting people’s health and safety while being closely associated with psychological motivations underlying intergroup conflict ([McKee and Bohannon, 2016](#)).

The Best Interest Standard

Parents want to do what is in their child’s best interest. This cornerstone of pediatric ethics is an established standard that we judge ethical decision making against: the best interest standard, which states that the surrogate decision maker (in this situation the parents) must “determine the highest probable net benefit among the available options, assigning different weights to interests the patient has in each option balanced against their inherent risks, burdens, or costs” ([Beauchamp & Childress, p. 228](#)).

It can be easily argued that “anti-vaxxer” parents are utilizing a form of the best interest standard, but one that has been impacted by erroneous information. These families are weighing the risks and benefits of vaccines, believing that they come with the risks of harm and exposure to other factors for their child, against the benefits, that they do not see as a beneficial because of a belief in natural immunity that is at least as effective as vaccines, if not more so ([Anti-Vaxxer Site](#))

Arguably, this means these parents are using proper ethical surrogate decision making, but one that is wrongly swayed by false information. While these parents are usually distrustful of traditional medicine, many are not aggressively so, nor do they hold fast to established beliefs that cannot be overturned ([Larson et al., 2018](#)). Many have been impacted by erroneous marketing claims of pharmaceutical companies regarding product safety and effectiveness. That erosion of trust has led to parents seeking alternatives in many situations or rejecting outright the claims of pharma's direct to consumer marketing (<https://undark.org/2019/04/24/anti-vaxxers-vaccines-trust-big-pharma/>). These families are concerned with the well-being of their child, in addition to being convinced of their rightness of their skepticism about traditional systems of care. We can all relate to that. These families, want to do what's best for their child, but understandably fall prey to the belief that others do not hold that same conviction regarding their child's best interest, including those who are members of the more affluent majority ([Yang et al., 2016](#)).

Balancing Rights

This different perspective, however, fails to address the central question regarding proper and compelling treatment. One of the most difficult ethical aspects of the vaccination question is that decisions made by these families impact all of society, not just themselves. If this was not the case and the consequences of refusing to vaccinate only impacted the unvaccinated, it would be more ethically permissible. As long as families were properly educated and able to give informed refusal, then under the principle of respect for autonomy the provider cannot compel treatment. But we know this is not the case, and their decision impacts the larger public's health concerns; from herd immunity to prevalence of the viruses and exposure to individuals with compromised immune systems and those unable to receive vaccinations (e.g., children under the age of one).

Should the rights of an individual be subject to the benefits of the general public? What precedent does that establish? How are physicians to handle these patient situations ethically?

One option is dismissal/transfer of the patient to another provider. This option is often sought in response to the provider's position that trust needs to be maintained for the physician/patient relationship to achieve mutual benefit. If trust erodes due to the patient/surrogate's refusing to participate in or distrust of care, then the relationship may be damaged beyond repair. Physician belief that dismissal and referral to another provider poses liability challenges, however, because "while the law on dismissing families for vaccine refusal is not certain, it is possible that a physician who stopped treating a family on the basis of vaccine refusal before the family was successfully transferred to another physician would be liable in negligence for harm suffered by any family members caused by the lack of access" ([Halperin et al. 2007, p. 844](#)).

Continued Engagement

According to the principle of respect for autonomy, a patient's decision that the provider is not in agreement with, should not preclude a patient or family from receiving ongoing care ([Halperin et al., 2007, p. 844](#)). Therefore, a more ethical route would be continued engagement with the patient and family and a focus on building trust and understanding of the need for adherence to public health safety standards.

As mentioned before, these families are dealing with myriad concerns including distrust, fear, safety, options/other alternatives, and confusion that afford multiple opportunities for further engagement. Communication and shared decision making typically result in better outcomes for both the patient and the provider, so "while there is no perfect solution, educating physicians about the value of mediating disagreements through communication that is respectful of the patient's perspective may preserve the integrity of the relationship and allow further exploration of options regarding vaccination" ([p. 845](#)). In other words, keep talking.

Bioethics in the News

[Your Immortality Application](#)

[Racial bias in a medical algorithm favors white patients over sicker black patients](#)

[Expert questions decision to withdraw nutrition from Colorado girl whose mother is now charged with murder](#)

[Researchers cast spotlight on Dutch euthanasia for dementia](#)

[Journal of Health and Human Experience](#)

Case Study

Patient is a 6-year-old female being seen at her family physician. The patient is up-to-date with all of her vaccines, but the patient's mother is now expressing concerns. The mother is saying that after receiving his one-year vaccines, the patient's younger sibling (1-year old male) started showing signs of autism. Now, the patient is to receive her latest DTaP, MMR, IPV, and Varicella, but her mother is saying that she thinks she better not. You are their family physician. Do you allow the mother to refuse the vaccines? How do you engage with the mother to participate? If the mother continues to refuse, should you dismiss the family?

Ethical Musings

Do No Harm

Primum non nocere, roughly meaning "Above all [or first] do no harm," is often cited as the cornerstone of medical ethics and medical professionalism. If you ask the average person what they know about medical ethics, most would say they know the Hippocratic Oath and that doctors must follow "do no harm." It has even been argued that all other ethical principles (autonomy, beneficence, and justice) are just different versions of nonmaleficence. Not doing harm comes in the form of respecting individuals and their right to self-determination, by only providing good and benefits, and by treating patients equally. The importance of the principle of nonmaleficence is even expressed through its language Primum non nocere, primum meaning "first, or above," essentially stating that refraining from harm should come before all other aspects of patient care and ethical principles.

What Is Harm?

All medical treatments and procedures come with some level of harm. This is unavoidable. Only when weighed against the potential benefits of the treatment can we determine whether the harm is acceptable. Therefore, this is not the avoidance of harm but rather avoidance of unnecessary harm. As Beauchamp and Childress state, "The principle of nonmaleficence is a prima facie principle that requires the justification of harmful actions" ([Beauchamp and Childress, p. 153](#)). Such harmful actions can be as minor as the minor puncture wound when administering an IV, which is so commonplace that most do not even consider it harm. Indeed, it is only when a patient is deathly afraid of needles that the reality of the action comes into focus.

Or the determination can involve far more aggressive treatment, such as chemotherapy or amputation of an infected limb. In these situations, the harms and benefits are closer to each other. This is when, with more moral ease, we allow patients to object to treatments. A provider would likely feel uncomfortable if a patient was refusing a minor procedure that would have a high level of benefit and low harm. That patient may even have his/her capacity in question because of the clear (to the provider) benefits. If, on the other hand, the benefits were not the clearest and the harms were much higher, that would be less problematic for most providers. Assumingly, far fewer providers would feel morally conflicted if a patient is refusing to start another round of chemotherapy when there is a low expectation of success.

Still, in both of these situations, the patient expresses his or her medical preference and right to autonomy, wanting to avoid a procedure that he/she believe is harm. What these examples demonstrate is that understanding the question, "What is harm?" is complicated.

Can We Impose Universal Standards?

Defining “harm” can be quite challenging for, as discussed, what harm may be for one patient may not be harm for another. Beauchamp and Childress construe harm as, “a thwarting, defeating, or setting back of some party’s interests” but continue that “a harmful action is not always a wrong or unjustified” ([Beauchamp and Childress, p. 153](#)), furthering the idea of harm versus unnecessary harm.

This demonstrates the challenge in defining any word. Alfred Tarski argues (in an extremely simplified approach to this work) that truth is a metalinguistic adjective and that true and false are only part of a particular language. There is not an inherited truth value to a particular sentence but only in how the sentence plays within its given language, a given language that can change with time. For example, “A man is a donkey” is a true sentence if and only if a man is a donkey. But the words man and donkey can change or have different meanings in different languages. Therefore, we cannot say “A man is a donkey” is a true or false sentence, only that it may have been true. ([The Encyclopedia of Philosophy, 2: p. 230](#)).

Tarski’s argument relates to the challenge of applying true and false to ideas, sentences, and concepts. Applying this to the clinical setting and harm, can we say with certainty that a particular treatment is a good or a harm? Can we say that vaccines are a known good and allowing a patient to refuse vaccinations is a violation of *Primum non nocere*? These thoughts are not to say that vaccines are wrong or that patients should not be encouraged to have them. But rather that imposing universal standards of what is a harm and what is a good is far more challenging than we may like it to be.