

3 Forgoing Vaccination: Reasons and Rights

Since the introduction of the first large-scale programs at the beginning of the nineteenth century, vaccination has become both a lauded and a controversial phenomenon. Most parents voluntarily enroll their children in such programs because they are convinced of the beneficial effect of vaccination on the health of their children. But a significant percentage of citizens remain unwilling to accept vaccination for themselves or their children—even when there is a clear threat such as COVID-19. This chapter discusses the various causes of vaccine hesitancy: the delay in acceptance or refusal of vaccinations that are available and easily accessible through national programs. Some objections to immunization are embedded in a comprehensive secular or religious view of life, while others fit in a more rationalistic perspective. In the upcoming sections, we present and discuss three types of reasons that some groups of people have for objecting to vaccination. These reasons may crosscut each other, so our taxonomy of reasons can be considered a heuristic separation of partly overlapping perspectives.¹

In the second part of this chapter (from section 3.5 onward), we argue that in a pluralistic democratic state, these objections should not simply be ignored by the government; instead it should, to a large extent, respect citizens' freedom to make their own choices about accepting or rejecting preventive options for themselves and, to some extent, for their children.

3.1 Religious Opposition to Vaccination: Divine Providence

The first category of vaccine objections is of a clearly religious nature: it concerns persons who are convinced that vaccination interferes with divine providence or that a disease is a spiritual phenomenon that should be healed

or prevented through prayer instead of medication. Examples are concerns endorsed in specific Protestant Christian congregations, notably in the Netherlands and the US. One of the most perseverant types of groups that oppose vaccination are “*pietistic reformed groups*” (*bevindelijk gereformeerden*): orthodox Protestant communities in the Netherlands, consisting of about 250,000 members (Ruijs, 2012, pp. 7–24; van der Meiden, 1993, pp. 60–72; Zwemer, 2001, pp. 14–19). They believe that God has predestined the fate and therefore also health and illness of all human beings. They are aware of the risks of vaccine-preventable disease and disease outbreaks, will fear the possible negative health effects for themselves or their children, and might fully acknowledge the medical effectiveness of immunization. Nevertheless, they oppose vaccination for themselves and their children because they prioritize their religious values and faith in God over the medical benefits of immunization. Taking divine providence as a starting point, vaccination could be considered an “inappropriate meddling in the work of God.” Moreover, immunization would be evidence of a lack of trust in God and a refusal to submit to divine discipline or punishment. Such arguments are usually supported by references to Matthew 9:12: “It is not the healthy who need a doctor, but the sick.” This quote suggests a categorical distinction between medical prevention and therapy. The former is prohibited while the latter is allowed. A somewhat different attitude is common among Christian Scientists in North America. They argue that disease is a spiritual rather than a material phenomenon that should be healed through prayer rather than by medical interventions. Members of this religious community refuse vaccines because they believe that physical illness is an illusion of the material world and that prayer can help us to correct the false beliefs that give rise to illness (Colgrove, 2005). A further religious objection that is sometimes invoked is that research on or production of certain vaccines would have involved the use of cell lines derived from aborted fetuses (Giubilini et al., 2021).

From an epidemiological perspective, it is relevant that these religious groups often live in tightly knit and geographically concentrated communities that are sometimes even relatively closed. As a result, vaccine coverage in these communities and villages will be very low, creating conditions for infectious diseases to spread rapidly within the group (Ruijs, 2012, pp. 136–148). Indeed, in the past few decades, the so-called Bible Belt region in the Netherlands has seen various outbreaks of polio (1971, 1978, 1992), measles (2000, 2013), and rubella (2004). It is clear that members of these religious

congregations usually have very strong and principled objections against vaccination.² And even though they may deplore the possible health risks for their children, they postulate that their fate—whether or not they are infected with measles—is ultimately in God’s hands and that humans should not meddle with divine providence through vaccination.

3.2 Anthroposophist Objections: Diseases Contribute to Development

The second group of objections centers on the assumption that certain childhood diseases have a beneficial role in the physical, mental, and spiritual development of children. This idea is based on the philosophy of anthroposophy as formulated by Rudolf Steiner (1861–1925), which is especially endorsed in some regions in South Germany and Switzerland. As an educational philosophy, anthroposophy is prominent in over a thousand Waldorf schools all over the world (Navin, 2016, pp. 117–120). Many people in these communities also embrace anthroposophical approaches to medicine (Bartelme, 2020). There is no formalized policy on immunization within the practice of anthroposophist medicine. However, the basic assumption is that a disease such as measles is seen as a relatively innocent but necessary struggle in the process of a child’s development into an adult—on par with losing primary teeth. The anthroposophist doctrine explains that such childhood diseases provide individuals with a natural resilience against diseases like cancer and allergies later in life. Measles and some other childhood diseases are seen as innocent and beneficial, so followers of Steiner’s anthroposophy prefer their children to encounter rather than avoid these infections. Medical practitioners should therefore not prevent this through vaccination but instead should help the patient to deal with the illness. Arthur Allen quotes a parent of a child in a Waldorf school:

There’s a little bit of soulfulness with getting ill. . . . Sometimes people say that after a fever you see a difference in a child’s being. It really strengthens them. . . . [People who vaccinate their children] never allow them the soulfulness of being ill. (Allen, 2007, p. 351)

This is why some families seek to expose their young children to infections rather than prevent such exposure by means of vaccination. They even organize so-called measles parties—to *put spots on tots*. Although followers of Steiner’s anthroposophy might not live in communities that are as close as those of the Protestant religious groups discussed in the previous section,

their often unvaccinated children probably do go to the same Waldorf schools, childcare centers, and summer camps. This can result in local unvaccinated pockets, as noted previously, in an otherwise robust herd immunity, and outbreaks of measles and other vaccine-preventable diseases in anthroposophist schools or school camps are not uncommon.

3.3 Concerns about Risks and Benefits: Autism and Beyond

The third category of objections to vaccination is raised by people who suspect that the risks of vaccination outweigh the purported benefits. It is not strange for parents to be concerned about potential adverse effects of a vaccine for their child, but for the past two decades or so these worries are also actively promoted and spread by a vocal movement in which many members can be seen as being *antivaccination*. They convey their message through social media, books, websites, and documentaries. It is a multifaceted movement that includes “spiritual” or “holistic” approaches, adherents of “natural healing” and “alternative healing,” and those who oppose employing “nonnatural” means of promoting one’s health. Their critique of vaccination is sometimes embedded in a more encompassing view of life, like anthroposophy, a “back to nature philosophy,” or the idea that one’s body is a temple or otherwise sacred. But it might also find support in more down-to-earth sociopolitical sentiments like a lack of trust in government, public health authorities, scientific institutions, and “Big Pharma.” The different perspectives find one another in their shared critique of the ways governments organize and promote large-scale vaccination programs. Unlike religious groups, which are primarily inwardly oriented, antivaccination movements actively and successfully reach out to young parents, sometimes with the help of celebrities and often by stimulating parents to “do their own research” rather than following the advice of mainstream medicine.

An important event that has worked as a catalyst for this modern antivaccination movement is the *MMR-vaccine-causes-autism* controversy that was triggered by the publication of an article by Andrew Wakefield and coauthors in *The Lancet* (1998). Wakefield presented a study that suggested a link between the MMR (measles, mumps, rubella) triple vaccine, bowel disease, and autism. The link was widely reported in the media and led to societal unrest and a sharp decline in MMR vaccine uptake in the UK and other

countries. As a result, measles outbreaks started to rise again. The controversy generated a huge industry of peer-reviewed studies, none of which could corroborate the alleged vaccination–autism link (Jain et al., 2015; Taylor et al., 2014). *The Lancet* retracted the article in 2010 because it was discovered that the study was based on fraudulent data and because Wakefield appeared to have had undisclosed financial interests in establishing a link with autism and bowel disease (Deer, 2011a, 2011b). Soon afterward, Wakefield was struck off the medical register and thus banned from practicing medicine in the UK. Wakefield’s claim has been fully debunked in medical science, but the suggested link between the vaccine and autism remains “the most damaging medical hoax of the last 100 years” (Flaherty, 2011, p. 1302). Antivaccination groups and even some politicians continue to accept and repeat it as if it is a matter of fact.

Many vaccine critics seek to carve out “all-natural” lives for themselves and their children, to maintain “purity” or avoid contamination. They point to allegedly toxic substances, either the vaccine itself or adjuvants that play a role in creating a stronger immune response or that are used to preserve the vaccine. Others argue that current programs overwhelm a child’s immune system because it is forced to handle too many vaccines too early in life (Biss, 2014).

All in all, even if there is ample biomedical and epidemiological evidence about the safety of vaccines in such collective programs, parents may well have doubts and remain hesitant about vaccination. Like all medicines, vaccines can also have side effects. Even when all reasonable precautions are taken in the manufacture and delivery of vaccinations, it is inevitable that adverse reactions occur. Most side effects are local, minor, and unavoidable. The purpose of vaccination is to elicit a response from the immune system, and this is often accompanied by temporary symptoms. These symptoms indicate that the vaccine is doing its work, emulating infection, inducing the requisite immune response by the body, and building protection against the disease for which the vaccine is a proxy. Major harmful effects that can be causally linked to the vaccine are exceptionally rare nowadays. For example, the live oral polio vaccine can cause paralytic polio in very rare cases, and this has been a reason for most countries to switch to the inactivated injectable vaccine. Such major adverse effects are extremely rare for the vaccines used in current collective programs.

It is not hard to understand that parents worry about vaccines and the risk of side effects, given that most vaccine-preventable diseases have become virtually invisible in modern societies. Few parents have any idea about what polio, measles, or a meningococcal infection would mean for their child. Against the background of a very low incidence of these diseases and a concurrent high vaccination rate that results in group immunity, forgoing vaccination might even be considered a rational choice—at least from a self-interested individualistic perspective.

Seeing modern vaccine refusers as fully rational fact-driven deciders, however, is questionable. What unites modern vaccine critics more generally is their view that vaccines might be more dangerous than the diseases they aim to prevent. They actively dispute medical evidence—mostly, in general, “mainstream” biomedical and epidemiological science—and question the ways in which governments provide and promote large-scale vaccination programs. They overestimate the risks of vaccines, and their counterarguments are often fueled by elements of a metaphysical worldview that emphasizes “naturalness” or the purity of the body: they see vaccination, for example, as injecting a human body with a “foreign” substance that is unnatural and thus contaminates the purity of themselves or their newborn child. Their views find support in conspiracy theories on social media, such as the belief that pharmaceutical companies and governments are covering up information about vaccines being unsafe or ineffective. These communications can easily affect people’s intention to be vaccinated (Jolley & Douglas, 2014). Parents are encouraged to do their own research (on the internet) and to form their own judgment instead of trusting what governments and physicians say. Doing one’s own research is seen to make sense because of alleged biases in scientific research: mainstream science cannot be trusted because it is funded by a pharmaceutical industry that just wants to sell as many vaccines as possible. In these ways, vaccine critics are sowing the seeds of doubt about government-led immunization programs. By appealing to generic concerns about risks, financial interests, and government paternalism, these groups have a much stronger “outreach” and influence than the religious opponents of vaccination.³

Mark Navin explains that many parents hook on to this movement after having become disappointed with mainstream medicine or after having felt that their concerns were not taken seriously (Navin, 2016, pp. 21–56). They turn their back on regular health care, seek health providers who will not

challenge their beliefs, and sometimes form or join *alternative communities of knowers* (Nyhan et al., 2014). These are explicitly antipaternalistic and anti-authoritarian communities that provide ample space for sidelined voices, including self-identified *parent-researchers* who primarily employ web-based research. Moreover, these communities emphatically endorse democratic norms for allocating epistemic authority:

Democratization movements and the advent of the Internet have changed the environment around vaccines from top-down expert-to-consumer (vertical) communication towards non-hierarchical, dialogue-based (horizontal) communication, through which the public increasingly questions recommendations of experts and public institutions on the basis of their own, often web-based, research. (Larson et al., 2011, p. 528)

Inspired by these movements, some parents may reject or delay some or all vaccinations for their child, while others will just forgo those vaccines that aim to prevent what they consider to be “innocent diseases”—mumps, varicella, measles, whooping cough—and only protect their child against diseases they consider very dangerous—like diphtheria and polio. The anti-vaccination movement not only is “successful” in persuading people to actively refuse immunizations for their child but also encourages vaccine hesitancy, uncertainty, and doubt among other parents, prompting them to at least postpone vaccinations, request separate vaccines rather than a combination vaccine like MMR, and avoid more than one shot at a time. During the COVID-19 pandemic, when debates about immunization became even more polarized, these strategies were also employed to raise doubts about the novel pandemic vaccines.

3.4 Epistemic Controversies

Even though vaccine criticism is as old as vaccination itself, the current wave of antivaccination sentiment seems to be more intense than earlier resistance and is more capable of attracting the attention of parents still on the fence.⁴ Wakefield’s MMR *vaccine-causes-autism* claim has propelled a new wave of vaccine critique. A second cause of the upsurge is that the internet and new social media platforms like Facebook and Twitter have offered vaccine critics an unprecedented opportunity to diffuse their message to a much wider audience. How can we understand these phenomena? In this section, we argue that modern vaccine criticism and resistance may be considered

symptoms of a broader individualism and of erosion of trust in collective institutions.

When large-scale routine immunizations against poliomyelitis, diphtheria, and other diseases were introduced, this was mostly heralded as a decisive strategy against horrible disease outbreaks. Their success in preventing epidemics and reducing morbidity and mortality was remarkable. Moreover, they arrived at a time when there was strong collective trust in medical authorities and (governmental) public health institutions. People generally seemed to endorse a social contract–like agreement: everyone participated in vaccination programs so that everyone was protected.

However, over time, the collective optimism about the benefits of vaccination slowly evaporated. The urgent public health aim of fighting infectious diseases, quite paradoxically, lost its status and visibility as the devastating effects of these diseases faded from the collective memory. This development coincided with a second, more general social phenomenon of an emerging individualism in the Western world. The collectivist spirit that had sparked the trust in and success of vaccination programs in the early sixties and seventies gradually became overshadowed by a more individualistic assessment of vaccination. As large outbreaks of infectious diseases became less common or even remained absent in high-income countries, people's attention shifted from the importance of protection against epidemics to the (alleged) risks of vaccinations.

Nowadays, a substantial number of worried parents may not be reassured by knowing that the MMR vaccine is effective in protecting against disease and contributes to herd immunity and that, on a population level, the health benefits of vaccination clearly outweigh potential adverse reactions. Instead, such parents are more interested in the question of whether the MMR vaccine is safe for *their own child*. Childhood vaccination programs aiming to preserve herd immunity ultimately lead to a trade-off. Thanks to these programs, individual children are immune, society is safer, and immunocompromised persons and newborn babies are indirectly protected. If a robust group-level protection has been established, it may appear as if vaccination for one's own child is not urgent: they are already protected indirectly. As a result, the attention of many parents has shifted from concerns about disease outbreaks to the risks associated with vaccination.

It may be attractive for proponents of vaccination to reduce vaccine denialism to irrational and antiscientific beliefs. After all, there is overwhelming scientific evidence in support of modern vaccination programs;

population benefits far exceed harmful side effects. However, Goldenberg and other *science, technology, and society* scholars emphasize that public questioning of vaccines in the twenty-first century cannot merely be understood in terms of an antisience ideology or a misunderstanding of the science (Goldenberg, 2016; Koerth-Baker, 2016). They argue that part of the vaccine criticism and hesitance can be explained by the unilateral focus of scientists and public health authorities on population-level benefits, which largely misses the individual-oriented concerns of parents. This implies, they suggest, that government should not jadedly and repetitively rehearse the importance of herd immunity but instead should engage with parents' arguments about what is best for *their child*.⁵ This does not imply that governments must accept every objection to vaccination without scrutiny. But it does require a reorientation of the way governmental agencies communicate the importance of vaccination, not only in terms of a collective focus on public health but also in terms of the best interests of the child involved.

Although Goldenberg and other scholars have a valid point here, governments cannot avoid acknowledging that individualized perspectives will result in a collective-action problem: on an individual basis, for the parents of any child living in a context of herd immunity, it might even be rational to forgo vaccination. At the same time, accepting these individualized perspectives at face value is ultimately self-defeating as a policy. If more parents avoid the minimal risk that vaccinating their child entails, fewer children are vaccinated, which increases the likelihood of an outbreak. Vaccination, as well as yielding a private good—the protection of the individual—also contributes to the public good of herd immunity. The collective-action character of herd immunity has long been unnoticed, because group protection simply flowed from large numbers of parents who had their children vaccinated for private, not collective, reasons primarily concerned with the health of their offspring. Herd immunity achieved in this way is only a positive externality that results from many private choices. The trend of diminishing vaccination rates in the first decades of this millennium shows that herd immunity does not have a stable basis: it is in fact a contingent positive externality of individual choices that can evaporate over time.

It is only to be expected that parents would reconsider their vaccine hesitancy if risks of measles outbreaks reappear. But it would be cynical for a government to wait until outbreaks recur to regenerate public awareness of the dangers of vaccine-preventable childhood diseases—doing so would sacrifice the health or even the lives of children. Moreover, one cannot expect

that most vaccine-hesitant people will change their mind if the risks are less remote: vaccine refusal has also been common during the COVID-19 pandemic. Many people had doubts about the severity of the disease and assumed that vaccination was unnecessary. Luckily, a large majority of people do participate in regular national programs, and vaccine denialism remains only a minority view.⁶ At the same time, coverage of childhood immunization has decreased throughout the past few decades in many countries. Antivaccination groups appear to have been successful in influencing parents who are uncertain but feel that they are responsible for making their own choice about vaccination. As mentioned previously, they herald the idea that each parent should do their own research and form their own judgment about the benefits and burdens of vaccination. Social media enable laypersons to exchange stories, rumors, and experiences with other parents. They can even explore the vast collection of biomedical scientific literature. Parents who are interested and concerned about side effects of vaccines will easily find sources that are in line with those concerns: personal anecdotes of parents whose children became severely ill just days after being immunized or scientific reports about side effects. Antivaccination groups are eager to bring all such experiences, alleged experiences, anecdotes, and scientific reports together and then invite other parents to read it, which is framed as “doing their own research” and “making up their own mind.”

Developing a well-informed position in this debate is, however, less straightforward than these groups make it seem. Scientific research into vaccination has produced a robust body of knowledge that has been generated over a long period of time and is based on research in various disciplines. Yet the conclusions drawn from this research are not offered on a silver platter in a straightforward way. Instead, they are to be derived from many articles that are scattered across a large range of scientific journals. To genuinely appreciate this body of knowledge, one needs to have a comprehensive view of the evidence. One cannot conclude on the basis of one or two (or even dozens of) scientific articles that vaccines do or do not work or that they are harmful. It is easy to find scientific publications that note harmful effects. It is even easier to find publications that emphasize the benefits. But a good scientific judgment must be based on a review of the entire body of knowledge in the field.

It is already hard for professionals to keep up with the literature, so it is virtually impossible for laypeople to develop an overview of the scientific field. By suggesting that laypeople can “do their own research” and by

emphasizing that everyone is able to determine what the risks and benefits of vaccines are, vaccine critics suggest they take a neutral stance (“respecting autonomy”). But in fact, they undermine public confidence in science, in biomedical scientists and other experts, and in public health programs.

Given the fact that most citizens are not experts in this field, participating in national immunization programs presupposes a certain level of public trust in vaccinations and in the government agencies and professionals that implement them. This implies that citizens have to accept medical expertise and competence and that they defer to specialists the weighing of risks and benefits concerning issues beyond their knowledge (Sorrell, 2007). Maintaining that trust, or gaining it if it is not already there, is a difficult task. We discuss the problem of trust in more depth in chapter 9.

Even if, from a medical or public health point of view, immunization is the preferred (if not obviously best) choice, no one can deny the reality of epistemic and ethical disputes about deciding whether or not to participate. Whether people object to vaccination for religious reasons, because of a particular “nature-centered” worldview, because they are more concerned about the risks than about the benefits of immunization, or because they simply do not trust mainstream scientists or government officials, such objections cannot just be pushed aside by appealing to a scientific and professional consensus. This is not only because a blunt rejection of concerns might easily reinforce distrust in health authorities. Much more importantly, in a liberal-democratic society, the plurality of worldviews should be acknowledged and therefore the concerns and choices of citizens must be taken seriously—also if these choices are not in line with scientifically grounded medical recommendations.

3.5 Taking Opposition Seriously

A core characteristic of liberal democracies is that the freedom and autonomy of citizens are respected and considered cornerstones of the liberal-democratic tradition itself. Respect for personal autonomy implies that citizens have the freedom to form and revise their conceptions of the good life and to organize their lives accordingly. This acknowledges the Kantian normative axiom that all human beings have equal dignity, which implies that no person or group is allowed to dominate, suppress, or otherwise impose their will on others. It also recognizes the value of a plurality of different and sometimes conflicting ideas of the good life and, indeed, that

a good society is one where people with different worldviews—religious or secular—can coexist peacefully. In the long run, a good quality of life is best attained if individuals are free, in a negative as well as a positive sense, to make their own choices (and mistakes) in life.

At the same time, liberty is inevitably limited: if all persons deserve respect, then each person's liberty is necessarily constrained by the liberty of others. As John Rawls's first principle of justice formulates, each citizen in a liberal-democratic state "is to have an equal right to the most extensive total system of equal basic liberties that is *compatible with a similar system of liberty for all*" (Rawls, 1971/1999, p. 266, emphasis added). Indeed, one of the key questions of liberal-democratic political philosophy concerns the legitimate constraints on individual freedom and whether there are further grounds for interfering with individual freedom apart from liberty itself.

This implies that government should provide space in which citizens can make up their own mind about vaccination and that it takes those persons who express objections to vaccination seriously. This has important implications for our discussion on vaccination hesitancy and refusal. Vaccine-hesitant citizens can have various reasons why they reject vaccination. Many of them refer to a fundamental gut feeling about "autonomy" or "noninterference" and the belief that decisions concerning immunization of themselves and their child are *their* choices, which government should not interfere in. Even though these are fundamental and legitimate *moral* convictions, they need to be unpacked and translated into relevant *legal* rights before they can be invoked as a shield against interference by government. This implies that the predominantly moral concepts of autonomy and noninterference must be "disaggregated" (Laborde, 2017) into specific legal claims that are acknowledged by courts and have to be realized to a certain threshold to guarantee autonomy.

In the context of immunization policies, respect for personal autonomy can be unpacked and linked to specific legal rights by appealing to the notions of *bodily integrity*, *freedom of thought and religion*, and a *right to family life and parental autonomy*. In the remaining sections of this chapter, we aim to formulate the argument for respecting objections to immunization in the strongest possible sense. More precisely, we argue that a democratic government cannot set objections aside just because they have good medical and public health reasons for aiming at high immunization rates. Chapters 4 through 7 discuss the limitations of this argument in the case of childhood

vaccination; chapter 8 discusses the limitations of coercive vaccination of adults. In those chapters, we explain how, even though the objections are taken seriously, government is sometimes allowed and required to introduce liberty-limiting measures to promote immunization.

3.6 Bodily Integrity

The freedom to decide what others can(not) do with one's body or the freedom to resist others to intervene in one's body is arguably a fundamental right of every person. This right is sometimes linked to the idea of self-ownership (Locke, 1988; Nozick, 1974). Moreover, if we assume that human beings have a right to privacy, then the bodily sphere seems to be "private" in the most basic sense. Any idea concerning personal autonomy and privacy is devoid of content if it does not contain a right to control interventions in and on one's body.⁷ For that reason, it is now generally accepted that a medical intervention should not be imposed on an individual without their *informed consent*. A competent person's well-considered refusal of medical treatment is not an absolute barrier for physicians starting or continuing therapy but certainly one that is almost unsurpassable. Health care professionals may have good reasons to question a person's choice to refuse medically beneficial treatment, but if it appears that the patient's refusal is a well-informed, well-considered, and voluntary choice, they will, rightly, abide by it. This is not only in line with a basic idea about respect for autonomy; normally, an individual will also be the best judge of their own best interests, which are broader than health alone. Obtaining informed consent for medical interventions is therefore firmly embedded in medical ethics and medical law, but that does not imply that it is merely a matter of professional obligation within health care: the grounds for requiring informed consent for medical treatment apply to other persons, institutions, and governmental agencies too. The Dutch constitution expresses this explicitly as the inviolability of the human body. According to article 8 of the European Convention of Human Rights (ECHR) jurisprudence, the right to private life also includes "the physical and moral integrity of the person."⁸ The European Court of Human Rights concluded that "even minor medical treatment against the patient's will must be regarded as an interference with the right to respect for private life."⁹

These fundamental human rights protecting bodily integrity are not absolute, and often legal provisions specify under what conditions the state

is allowed to make exceptions. In liberal democracies, those exceptions are quite limited. Some examples are taking blood or saliva samples from convicted criminals for DNA analysis or doing alcohol-level tests on car drivers. It might be argued that mandatory seatbelt wearing is also a restriction of the right to bodily integrity; this measure is common and presumably widely accepted in all jurisdictions. The clearest cases in which “bodily integrity” is at stake, however, concern interventions or actions that intervene *in* the body or cause physical pain—without proper consent. Vaccination certainly falls into that category, which is why it is a major barrier for public health authorities that want to require citizens to be vaccinated. Whether there is a sufficient ethical ground to justify compulsory vaccination programs, and therefore to see vaccination as a legitimate exception to the right to autonomy and bodily Integrity, remains to be seen.

Arguably, the rights to autonomy and bodily integrity are at their strongest when a competent person is refusing medical treatment for themselves. Autonomy and bodily integrity presuppose a unity of mind and body: *I determine what happens to my body*. Therefore, another person, including a medical doctor, is not allowed to do things to a person without their informed consent. This implies that the right to the integrity of the body presupposes a competent person who can autonomously accept or refuse an intervention. This will be an important argument in the discussion of vaccination for adults, for example, in the context of COVID-19, and we will discuss this in chapter 8.

However, in the context of childhood vaccination, this argument is less straightforward (Pierik & Verweij, 2022). Most programs target children who are not yet competent decision makers, so the authority to consent to medical treatment usually falls to their parents or legal guardian, and they are supposed to make such decisions based on the best interest of the child. It is not immediately obvious, however, that a medical intervention on a child without *the parent's* consent would be an infringement of *the child's* bodily integrity. Indeed, as we argue in chapter 5, when parents and the state disagree about what is in the best interests of the child, it is not always the case that parents have the final say. The American Academy of Pediatrics therefore also favors the language of “parental permission” instead of the much more stringent concept of parental *consent* (Katz et al., 2016).

To assess the validity and strength of the argument about the bodily integrity of the child, we must assess how the concept can be understood

in this context. One possible reading is to take bodily integrity literally, as “wholeness,” where surgery or other medical procedures interfere in the body and thus violate its integrity. This reading is untenable, though, as it would imply that many, if not all, medical interventions violate bodily integrity, even if parents had consented to treatment. It is, often, however, the other way around: medical interventions, if appropriate, aim to *preserve* bodily integrity where it is threatened due to an injury or disease. Successful therapeutic interventions heal persons and their bodies; they do not violate them. Preventive treatments like vaccines also preserve and protect bodily “wholeness” by making the body immune to certain infections. Of course, medical treatment can also have harmful side effects, and thus even well-intended vaccinations may occasionally threaten bodily health and integrity—but whether the preventive intervention can be considered *ex ante* as a violation of bodily integrity amounts to an assessment of the benefits and risks of the intervention for the child. In other words, arguments about bodily integrity ultimately amount to determining what is in the best interests of the child. Given the fact that young children are incapable of making such decisions themselves, and for reasons we discuss later (section 3.8 and chapter 5), it is the parents who are in principle designated as the guardians of their child and authorized to make choices in their best interests. Note, however, that by reducing the argument about bodily integrity to an assessment of a child’s best interests, the rhetorical force of the idea of bodily integrity itself evaporates.

Yet this view, that all body- or health-preserving interventions necessarily respect integrity, presupposes a concept of bodily integrity that is fully naturalistic or biomedical and disregards the *normative* meaning of integrity. Acknowledging the normative dimensions implies that a person’s bodily integrity is only at stake when their bodily sphere is invaded *by someone who is not authorized to do so*.¹⁰ In our view, there is always only one person who without any doubt can be considered having this authority, and that is the person whose body it is. Indeed, the normative force of the right to bodily integrity is this direct link: it is *your* right that it is *you* who determines what happens to *your* body. If the person whose body is interfered with cannot make the decision themselves to authorize the intervention, then the force of the argument deflates. When an authorization of a medical intervention must be made by a guardian—either parents or the state—there is no inherent argument *from the perspective of bodily integrity*

that explains why parents are *ipso facto* better situated to make this decision than the state. As we argue in chapter 5, parental prerogative is the most plausible starting point of this discussion, but it is not an absolute principle.

We have argued that in principle, the right to bodily integrity is a strong argument against governments imposing biomedical interventions on citizens. However, the right to bodily integrity is not absolute; it can still be overruled on other legal grounds, as happens in the case of mandatory alcohol tests, so it remains to be seen whether the right to bodily integrity is strong enough to overrule compulsory or mandatory immunization. In chapter 8, we elaborate further on this delicate balance between the individual right to bodily integrity and possible overriding concerns in the context of COVID-19 vaccination programs for adults.

Second, we have shown that the strength of appeals to the right to bodily integrity is highly questionable if it concerns childhood immunization. Parents cannot claim they are the sole guardian of their child's bodily integrity, and, moreover, it may even be argued that safe and effective immunization, even if imposed against the will of parents, preserves, rather than violates, the child's bodily integrity. This theme is elaborated further in chapter 5.

3.7 Freedom of Thought, Conscience, and Religion or Belief

A second fundamental ground for taking objections to immunization seriously is to respect liberty of thought and religion. The rights to freedom of thought, conscience, and religion or belief have been laid down in various international conventions, including the International Covenant on Civil and Political Rights (ICCPR, art. 18) and the ECHR (art. 9). These rights protect not only specific beliefs but also people's choices and desires to live in line with their religious beliefs or worldview or, as the ICCPR describes it, "to manifest his religion or belief in worship, observance, practice and teaching." Freedom of thought is one of the most basic prerequisites of a liberal democracy, sometimes even seen as "the basic and distinctive 'first freedom' in the liberal political order" (Pierik, 2015, p. 254).

It goes without saying that the concerns of some religious groups about immunization (e.g., that it interferes with divine providence) and the ensuing objections to vaccination policies fall under the scope of these rights. Enforcing immunization would obviously violate the liberty of members of these groups to live according to their religion. The same applies to comprehensive

anthroposophist worldviews that include metaphysical ideas implying that childhood diseases are important steps in a child's development. Moreover, the fundamental right at stake is not limited to religions or comprehensive worldviews; other convictions also deserve protection. The European Court does not require that substantial criteria are met for a person's conviction to qualify as a "belief" in the sense of the freedom of religion or belief. Instead, it simply requires that the conviction must display "a certain level of cogency, seriousness, cohesion, and importance."¹¹ Recently, however, the court concluded that the mere disbelief of facts about vaccination, without it being substantively embedded in a broader religious or philosophical worldview, cannot count as a coherent personal philosophy of life that is sufficient for protection under article 9 ("Vavříčka," 2021, ¶29, ¶335). Still, many parents embed their fear of side effects in a more comprehensive worldview, and therefore they may well be justified in arguing that their freedom of thought and religion are at stake. This brief discussion makes it clear that governments and public health professionals have very strong reasons to take objections against vaccination seriously and cannot just push them aside via coercive policies.

There are however, two caveats. First of all, as explained above, the protection of liberty and basic rights and respect for autonomy are fundamental moral and legal principles, but they cannot be absolute, specifically not when the health interests of other individuals, or of society at large, are at stake. This proviso is made explicit in the second section of article 9 of the European Convention:

Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

In more general terms, this proviso was famously put forward by John Stuart Mill in what is now called the harm principle: freedom can be legitimately constrained to prevent harm to others. The principle is relevant for vaccination programs to the extent that immunization not only protects the vaccinee but in most cases also contributes to the protection of other persons, for example, those who cannot be vaccinated. In the following chapters, we explore whether the case for vaccination is strong enough to justify setting limits on liberty.

The second caveat, which only applies in the context of childhood vaccination, is even more fundamental. It is questionable whether freedom of

thought, conscience, and the religion of parents also protect choices for their children. Adults have rights to freedom of religion, and hence the right to refuse vaccination because of their religion or worldview, but do such rights give them authority to decide for or against vaccination of their children? This issue is taken up in the following section. We argue that there is a strong moral and legal basis for parental prerogative in matters of preventive and curative medical treatment of their children. But as we show in later chapters, once again, such rights are certainly not absolute.

3.8 Respect for Parental Autonomy

So far, we have established that there are two strong yet not absolute ethical grounds, bodily integrity and freedom of conscience, for respecting and therefore not pushing aside people's refusal of and hesitance about vaccinations. These grounds are also backed by legal frameworks such as the European Convention of Human Rights and jurisprudence in the European Court. Both fundamental rights can be seen as protecting individual autonomy: a person's right to govern their own life and live according to their own conception of the good. What still needs to be established more clearly is whether and why such autonomy would also include the authority to make decisions for one's young children—does personal autonomy also imply *parental autonomy*?

Justifications for respecting parental autonomy can be consequentialist and nonconsequentialist. Consequentialist arguments will see parental autonomy as a means to promote other values, such as the well-being of the child and the family. Given that almost all parents care about their children and desire the best for them, and that they are in a very good position to assess their child's needs in specific situations, it is reasonable to assume that, normally, they will make choices that are in their child's best interests. The government might set certain standards (e.g., certain general requirements for a good education), but individual parents will be much better situated to decide which educational approach fits their child best. The same may apply to specific medical choices.

The second consequentialist ground for respecting parental autonomy is that parents may have to weigh conflicting interests and demands of children and other family members. Choices that are perfect for one child (e.g., a special school that is relatively far from home, a camping holiday

full of physical activities, saving more money for college) might be disadvantageous for her brother. Parents are well situated to decide trade-offs in a way that is best for the family as a whole. Fostering a safe, private sphere of family life can also contribute to establishing affective and caring relations between all family members and raising children in a way that means they learn to care for one another (Diekema, 2004, p. 244).

A first nonconsequentialist argument for granting parents authority to make decisions about what is best for their children is that parental *autonomy* is a necessary condition for parental *responsibility*. The idea that parents have special duties of care toward their children is only viable if they are also able to act and decide accordingly. Acting for the sake of duty presupposes freedom to do so; without freedom (even freedom to fail), responsibility is empty and meaningless.

The second nonconsequentialist argument revolves around the idea that for many parents and parents-to-be, their individual autonomy cannot easily be separated from parental autonomy. Giving birth to a child, caring for them, seeing them grow up, and educating them to become a person with a life of their own are all major elements of what constitutes *their own life* and can be decisive regarding what it is to live a good life. The choices that mothers and fathers make for their children thus also determine and shape their own lives. Moreover, for a person who takes their own view of the good life and their own values seriously, and who also deeply cares for their children, it would be a major restriction of freedom if they were not allowed to raise their children in line with those values or to expose their children to them and inspire their children to live according to those values.

The caveat we mentioned previously applies here as well: fundamental rights are not without limits. Yes, there are strong grounds for parental autonomy that gives parents authority to make pedagogic, educational, medical, and other important decisions for their young children. Parents have the freedom and responsibility to make decisions in their child's best interests as determined by the parents themselves—this is what parental autonomy is all about. However, their conception of *best* interests may sometimes conflict with what, from a higher-order perspective, is considered the child's most *basic* interests. In chapter 5, we explore this distinction between basic and best interests in depth, and we argue that a liberal-democratic government has a responsibility to secure basic interests of children and that this implies limits to parental autonomy.

This idea of parental autonomy is often framed in terms of a right to family life, as laid down in, for example, article 8 of the European Convention. But the Convention also makes clear that this right is not absolute. The second paragraph of article 8 asserts that statutes enacted by national parliaments can limit this freedom when it “is necessary in a democratic society . . . for the protection of health or morals, or for the protection of the rights and freedoms of others.” This has implications for the right of parents to refuse vaccination for their children. Indeed, in *Vavříčka*, the European Court decided that the parental prerogative not to vaccinate can legitimately be constrained if a coercive vaccination policy is necessary to protect children and the public against vaccine-preventable diseases (“*Vavříčka*,” 2021, ¶284–288).

3.9 Fundamental Rights and Their Limitations

In this chapter, we presented some of the main reasons specific groups have for rejecting vaccination for themselves or their children. In most countries, such strong objections are held only by relatively small minorities; most people do accept vaccinations without hesitation. At the same time, there are many who are at least hesitant or otherwise have doubts about vaccines, and these groups offer fertile ground for vocal antivaccination groups to share and spread their deep objections. This is a matter of concern for governments, public health authorities, and medical professionals. In a pluralist democratic state, the government cannot simply suppress deviant views or restrict the freedom of citizens to determine their own lives and, to some extent, those of their children. Hence, the conflicting ethical and legal considerations require further analysis to find answers that are reasonable and proportionate.

It should be emphasized that in both liberal-democratic political philosophy and liberal-democratic law, fundamental rights are paramount, and they can only be restricted under very explicit conditions. But this also implies that rights to the freedom of thought, conscience, and religion or belief cannot be absolute; in specific circumstances, they are subject to restrictions that are “in accordance with law” and “necessary in a democratic society to protect the rights and freedoms of others” (ECHR, art. 9). In a similar vein, the right to family life and the resulting right to parental autonomy can be restricted by the state when this is necessary to protect the interests of the child.

In the legal domain, the principle of proportionality is widely employed to determine whether an infringement of basic rights is justified. The central idea is that a government's interference in citizens' freedom must not be disproportional, given the goal the law seeks to achieve, which already presupposes implicitly that the law as such is justified. The principle is usually employed in a four-pronged test (Alexy, 2014, pp. 52–54; Brems & Lavrysen, 2015, p. 141; Klatt & Meister, 2012, pp. 8–10; Rivers, 2014). Given the circumstances of the case, four elements must be analyzed.

First, there must be a legitimate purpose for a measure that infringes the fundamental right. This condition is much more stringent than just the idea that the measure should have a goal that is beneficial. Not every societal benefit justifies what is at stake here: an infringement of liberty. If the state is to restrict individual liberty, the purpose should at least be an important element of the core tasks of the government. Some constitutions or conventions even specify what grounds are considered legitimate purposes for such an infringement and under what conditions these apply. For example, article 9 of the European Convention of Human Rights holds that “freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.”

Second, the measure must be suitable for achieving the purpose, and this can include a requirement that there is (scientific) evidence to show that the measure will do so. Obviously, if the measure is futile, the purpose cannot justify the restriction of fundamental freedoms. The second part of the condition—the ideal that the measure is *evidence based*—raises an important question: what level of evidence can be gained beforehand about the effectiveness of a policy measure? Even though intrusive policies need to be based on the best available scientific evidence, decisions will often also involve some level of uncertainty about effectiveness, as the various policies drafted in response to the COVID-19 pandemic have made perfectly clear.

Third, the measure, as well as being suitable for achieving the purpose, must also be *necessary* to achieve the purpose. That is, there should not be an alternative, less onerous measure that could achieve the purpose equally well. This principle is known as the *principle of subsidiarity*, or the principle of least restrictive alternative or least intrusive means.

Fourth and finally, the measure must be reasonable in view of the competing interests of the citizens at stake. This last element of the test of proportionality is certainly not the least important: it involves weighing the competing claims and values at stake. Is the infringement of certain fundamental liberties (respect for autonomy, freedom of thought and religion, right to family life) proportionate given the purpose and necessity of maintaining herd immunity?

This form of legal reasoning that revolves around the principle of proportionality seems to be more dominant in the European legal tradition (Kumm, 2007, p. 154), but “it is also an increasingly common feature of rights-based judicial review in most other constitutional democracies worldwide” (Dixon, 2017, p. 2199). Indeed, various authors have argued that, contrary to the widespread idea that the proportionality approach is quite alien to the US constitutional tradition, there are more similarities than dissimilarities and that the proportionality approach quite closely resembles a “strict scrutiny approach” (Jackson, 2015, pp. 3104–3120; Sweet & Mathews, 2019, pp. 96–162). In addition, the idea of a proportional weighing of values and principles is also central in medical-ethical and legal-philosophical discussions. Therefore, we endorse it as an important method for the analysis in this book.

The first condition is paramount and principled. If there is no legitimate purpose for a measure that infringes the fundamental right, the measure can never be justified. The latter three conditions concern weighting factors where all kinds of contextual arguments play a role. Jointly, these conditions typically structure legal judgments of, for example, the European Court of Human Rights. This court has the final say in cases where citizens contest the restriction of the individual exercise of a fundamental right by a state party to the Convention.

In the next two chapters, we first discuss the principled basis for state coercion. Can the use of force to compel people to get vaccinated be legitimate at all? What specific arguments apply if it is about parents refusing vaccination on behalf of their child? From chapter 6 onward, we explore in detail whether and how immunization policies can restrict liberty in proportionate ways.

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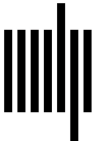
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