5 Basic and Best Interests in Childhood Immunization

In the previous chapter, we offered a principled argument claiming that governments are justified in imposing liberty-limiting vaccination policies when this is necessary to prevent harm to others. Diseases like measles pose a significant threat to public health in general and to the basic interests of vulnerable persons. These are the interests that government should protect by establishing the public health goal of herd immunity. We introduced Mill's harm principle, which offers a basis for justifying liberty-limiting vaccination policies, even if this involves a restriction of such basic rights as freedom of conscience, thought, or religion and the right to family life.

In this and the following two chapters, we answer what this implies for vaccination programs for young children. Should the state intervene in choices that parents make in the interests of their small children who are themselves not in a position to determine their own interests? In this chapter, we translate the more general harm principle into the "harm threshold" to answer why and under which circumstances government is allowed (and required) to interfere in parental prerogative. In chapters 6 and 7, we turn to the more contextual factors that determine which childhood vaccination policies are justified and proportionate in what circumstances.

5.1 Childhood Vaccination: The Focus on the Best Interests of the Child

In chapter 3, we discussed the arguments of science and technology scholars like Maya Goldenberg (2016), who emphasize that the current public questioning of childhood vaccination, in particular vaccination against measles, should be understood in terms of a different assessment of the risk of side effects caused by the MMR vaccination, given that the disease became virtually invisible in affluent countries. If, due to immunization programs, we

are confronted less and less with outbreaks of childhood diseases, concerns about the side effects of vaccines come into the limelight more. What if it turned out that your child is the exception that suffers from an extremely rare but severe adverse effect? These authors argue that the current vaccine hesitancy can, at least partly, be explained by the public image of vaccination programs being focused too much on increasing and maintaining the collective good of herd immunity, with too little attention given to parental considerations concerning the potential side effects of vaccination for their child. This implies, they hold, that state agencies should not repetitively rehearse the importance of collective benefits like herd immunity but, instead, should engage much more directly with parents' genuine questions about the risks for their child, both of the disease itself *and* of the vaccination against it.

Indeed, one of the determinants that characterizes the current debate is that parents increasingly require a justification of vaccination policies, and there is an uptick in more "active" parental participation in medical decision-making about their children. This dovetails quite nicely with the "best-interests standard," an approach in medical ethics and law used when making important decisions for persons who are not (yet) competent to make such decisions themselves. Since many of the available vaccinations are given to children in their first two years of life, they are not yet competent to make decisions about their own health. The basic idea is that, while making such a decision, the interests of the person involved should be the ultimate guide. This chapter takes this idea, that vaccination policies must be justified in terms of the interests of the child involved, as the starting point for the analysis. But it raises a fundamental question: if the child's best interests are the most important consideration in vaccination decision-making, who should have the final say when parents disagree with medical professionals or government agencies about how to understand these interests? We argue that state agencies can endorse this idea without also accepting what is usually implicitly embedded in this claim: that parents are the best interpreters of how to understand the interests of their child.

5.2 Best Interests, Basic Interests, and "What Is Best for Children"

Parents increasingly require a justification of vaccination policies in terms of the individual benefits for their child, which is, of course, something that

we normally expect parents to do. Inevitably, their judgment will be guided by their own conceptions of a good life and their own assessment of the circumstances. In situations where their child requires medical treatment, they will often depend on the pediatrician's assessment of the situation, and ideally, the pediatrician's medical view and their own judgment concur. From a legal and medical-ethical perspective, both are supposed to act in the best interest of the child, defined by Buchanan and Brock as "acting so as to promote maximally the good (i.e. wellbeing) of the incompetent individual" (Buchanan & Brock, 1989, p. 10).[1] The principle is central in children's law through article 3 of the United Nations Convention on the Rights of the Child (UNCRC), which emphasizes that in all actions concerning children, state agencies must take children's best interests as a *primary consideration*. The UNCRC explicitly focuses on children as separate right bearers because of their dependent position, giving them fewer opportunities to defend their interests themselves. In an elucidation, the Committee on the Rights of the Child writes,

> The expression "primary consideration" means that the child's best interests may not be considered on the same level as all other considerations. This strong position is justified by the special situation of the child: dependency, maturity, legal status and, often, voicelessness. Children have less possibility than adults to make a strong case for their own interests, and those involved in decisions affecting them must be explicitly aware of their interests. If the interests of children are not highlighted, they tend to be overlooked. (Committee on the Rights of the Child, 2013, §37)

If we acknowledge children as separate rights bearers, it becomes clear that "best interests" should be used as an objective standard for evaluating decisions that medical practitioners and parents make as fiduciaries *for* the child. However, in some cases, parents and medical practitioners disagree on whether a child needs a specific medical treatment. Jehovah's Witnesses' refusal to consent to a blood transfusion for their children—for example, in the case of a newborn "rhesus baby"—is widely discussed in the literature (Conti et al., 2018; Wolley, 2005). If medical treatment is necessary in cases of an imminent and severe threat to the health of a child, it is usually considered as being objectively in the best interest of that child. Indeed, in such acute situations, a best interests judgment made by medical practitioners and ultimately enforced by judges in a court is relatively straightforward, even if it is disputed by parents.

However, in the case of preventive treatments like vaccination, the "best interest" standard—understood objectively as "acting so as to promote maximally the good (i.e., wellbeing) of the incompetent individual"—is usually less straightforward as guidance. If a medical decision does not involve a situation of clear and present danger, many other medical and nonmedical considerations may also be relevant in determining what is best for the child. This is especially relevant in discussions about protection against major but relatively infrequently occurring risks. Why should a narrow medical perspective, which seeks to fully eliminate this particular health risk, always prevail in such cases? Indeed, absent imminent threats, it makes sense to pay more attention to a variety of (medical and nonmedical) factors that may affect the child's well-being, and different perspectives or worldviews will then lead to diverging judgments about what is best for the child. This implies that the singular conception of "best interests" is not much help in situations where parents contest nonurgent medical interventions proposed by medical specialists.

In the context of this dispute, we propose to unpack the term "best interests" and examine it as two terms: "what is best for the child," as determined by parents, and "basic interests," which is ultimately a matter of government responsibility. We define the concept of "what is best for the child" as the goals that parents are striving for when they raise their children in line with their idea of the good life. For various reasons, the concept should be understood in an open sense. First, there is a wide variety in how parents conceive these best interests, and the liberal state provides parents much leeway when raising their children in line with their ideas of the good life and transmitting those values to their children. This stems from the parental freedom of thought, conscience, and religion, which itself originates from the liberal idea of tolerance toward various ideas of the good life (see also section 3.7). Second, different children have different personalities. What might be good for one child to stimulate and develop them to their full potential might not be good for another. Since parents know their children best, they are in the best situation to assess their children's character, inclinations, talents, and what each needs to develop their potential.

This concept of "what is best for the child" as determined by parents must be clearly distinguished from "basic interests," for which state agencies have final responsibility.[2] Following John Rawls, we define "basic interests" as those higher-order interests that children have in developing and exercising

the basic capacities that are indispensable for growing up into a self-reliant and cooperating citizen in one's society (cf. Rawls, 1971/1999, p. viii). The state should ensure the background conditions and necessary prerequisites that guarantee each child's "open future" (Feinberg, 1980; Millum, 2014). Of course, the concepts "basic interests" and "open future" are contested, can be challenged, and should always be open for democratic contestation of some sort (Shapiro, 1999, p. 85). At the same time, child-rearing unavoidably presupposes certain ideas about what is indispensable in the development toward adulthood and which circumstances undermine this development. Pointing out that these ideas are intrinsically controversial does not undermine their necessity. Basic interests are essential, regardless of a child's individual character, convictions, or ideas of the good life. These include at least (Shapiro, 1999, p. 86):

- access to clean water and healthy nutrition;
- basic medical care, including protection against preventable lethal or disabling diseases;
- the protection of physical and social safety, including the right to grow up in a safe environment in which caring relations can flourish and in which the state does not interfere in family life without a compelling reason;
- basic education, enabling children to grow up into self-reliant citizens that can actively engage in our complex societies.

There is a broad legal consensus in democratic societies about the set of basic interests that the state should guarantee for its young citizens. And in virtually all political communities, this set includes protection against infectious diseases, for example, by means of implementing immunization programs.

In the context of medical decisions, we have replaced the singular notion of "best interests," prevalent in law and medical ethics, by the dual notions of "what is best for the child" and "basic interests." Indeed, despite the dominance of the best-interests parlance in constitutional and international law, it makes more sense to argue that the state only has the ultimate responsibility for a child's *basic interests*. After all, do we really think in the context of all-things-considered policies that a liberal-democratic state, restricted by the requirements of state neutrality, should pursue what maximizes the good of the child? Our dual terminology makes it clear that parents and state agencies share a dual regime structure of authority over children. Their roles are complementary since they have different provinces of legitimate authority

over children. The state has the fiduciary responsibility to look after the basic interests of children, and against that background, parents have the fiduciary obligation to make decisions about what is best for their child.[3]

In most cases, most of the time, the two fiduciary authorities work in tandem in complementary ways in the interests of the child. The concept of "basic interests" as just defined is in line with what most parents consider is best for their child. However, since there is no clear-cut division between "what is best" and "basic interests," border disputes may arise where the two fiduciary authorities overlap and conflict. Problems emerge when a parent's views of what is good for their child conflict with one or more dimensions of the political consensus on basic interests. People who endorse one or more of the objections we discussed in chapter 3 seem to have ideas about "best interests" that conflict with what is in their child's basic interest. Some parents still believe that the MMR vaccine causes autism, which gives them reason to consider vaccination harmful and hence not good for their child (Deer, 2011a, 2011b). Others follow Rudolf Steiner's anthroposophy and see measles merely as a harmless childhood disease and, simultaneously, as a necessary stage in the process of development from child to adulthood—on par with losing primary teeth. They might even be convinced that exposure to measles serves the best interest of their child. However, other parents insist on forgoing vaccination because they are seeking to carve out all-natural lives for their children, to maintain their purity, or to avoid contamination, assuming that vaccines contain toxic preservatives such as the mercury-based thimerosal.[4] What unites these parents is that they dispute the evidence of mainstream science that confirms vaccines are safe and effective; instead, they argue that immunization is much more dangerous than the risk of contracting the disease.[5] Their view of what is best for their child shares some of the core values of a "basic interests" standard—notably that a child's health is to be protected—but they disagree with the scientific basis of specific interventions that protect health.

In these discussions, vaccine-critical parents typically conflate two arguments. The first is that decisions about childhood vaccination should only be determined by the interests of the child involved; the second is that this implies that they, as parents, have the ultimate authority to determine what these interests are. However, these two claims are independent, and there is no reason why someone who accepts the first claim must also accept the second. We have already argued that vaccination serves a public good and

therefore should not solely be evaluated from the perspective of the interests of the individual child. But even if we do view vaccination decisions in terms of an individual child's interest, that does not imply that it is always up to parents to decide. Of course, as we explained in section 3.8, respect for parental autonomy is important. Government should not interfere unnecessarily in the parent–child relationship. It is also firmly embedded in international conventions. Article 18 of the International Covenant on Civil and Political Rights (ICCPR) protects the right to freedom of thought, conscience, and religion, while article 18(4) states that "the States Parties to the present Covenant undertake to have respect for the liberty of parents . . . to ensure the religious and moral education of their children in conformity with their own convictions." Article 2 of the First Protocol to the European Convention on Human Rights states, "In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions."

At the same time, and as argued previously, article 3 of the UNCRC directs states to protect the basic interests of children who cannot yet make a well-informed decision on vaccination. A prudent government policy strikes a reasonable balance between two rights: on the one hand, there is the right of nonvaccinating parents to raise their children according to their deeply held convictions and the corresponding duty of the government not to interfere with these parental choices. On the other hand, there is the right of the child to have their basic interests protected and to grow up in good health, including being protected against avoidable diseases—with the corresponding duty of the government to protect the rights of the child. The question that emerges, then, is under which circumstances should the state's responsibility to protect a child's basic interests overrule the right of parents to follow their deeply felt desire not to vaccinate?

5.3 Parental Prerogative or *Parens Patriae*? The Harm Threshold

It is generally taken for granted in liberal-democratic regimes that parents have the primary prerogative in the upbringing of their children. Neutrality requires the state to be agnostic toward the myriad ideas about the good life that parents may endorse, including their ideas about what is best for their children. Moreover, it is in the interests of both parents and children that

government does not unnecessarily interfere in the privacy of family life and the parent–child relationship as protected by, for example, article 8 of the ECHR.

Still, there remains a difference between the freedom of parents to live their own life in line with their idea of the good life and their freedom to raise their children as they like. Parents act as fiduciaries and guardians for their children, who are not yet capable of making deliberate choices—a role that slowly dissolves as the child approaches adulthood. Yet, from the very start at (or even before) birth, parenthood comes primarily with the obligation to protect the ongoing interests of children as vulnerable and maturing moral human beings who are in the process of developing into self-reliant persons.[6] Parental autonomy is not a self-standing right; it is a right that parents have *in their role* as parents and fiduciaries and in their endeavor of guiding their offspring toward independence. After all, children are neither an extension of their parents nor valid objects of their parents' self-expression. Instead, they are "self-originating sources of valid claims" (Rawls, 1980, p. 543). If parents fail to take on their role as parents responsibly, the state has a responsibility to intervene.

So, on the one hand, the state usually delegates its initial responsibility for children's basic interests to parents, working from the assumption that the decisions parents make follow their idea of what is best for their child and that this in turn also promotes the child's basic interests. Given the fact that most parents care deeply about their children and interact with them on a day-to-day basis, they will usually be better situated than any other actor, including the state, to understand the unique needs of their children and to make decisions that are in their children's best interests. On the other hand, the state never fully relinquishes final authority over a child's basic interests. Instead, it assumes a secondary and inverted role. It leaves most choices concerning child-rearing to parents and only interferes actively in parental autonomy when it is evident that a child's basic interests are (about to be) harmed because of parental decisions. That is, the state employs a "harm threshold," below which state interference is necessary and justified when basic interests are about to be harmed (Birchley, 2016a, 2016b; Diekema, 2004).

This concept of the "harm threshold" is, of course, a straightforward contextual application of Mill's harm principle that we introduced in chapter 4 as the main justification for liberty-limiting policies. The freedom of parents

to raise their children in line with their ideas of the good life is limited, since it should not result in the avoidable risk of harm to their children, death, or lifelong disability, and the state has an obligation to intervene to protect the infant when this can be done easily and safely (cf. Dawson, 2011, p. 146). The doctrine of *parens patriae* allows state interference to protect a child's basic interests, iconically established as a legal principle by the US Supreme Court in *Prince v. Massachusetts* (1943): "Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children."

In a recent case, the European Court argued that "the obligation on States to place the best interests of the child . . . at the center of all decisions affecting their health and development" concerns the interests of not only the child involved but all children as a group:

> When it comes to immunisation, the objective should be that every child is protected against serious diseases. In the great majority of cases, this is achieved by children receiving the full schedule of vaccinations during their early years. Those to whom such treatment cannot be administered are indirectly protected against contagious diseases as long as the requisite level of vaccination coverage is maintained in their community, i.e. their protection comes from herd immunity. ("Vavřička," 2021, p. 65, ¶288)

In pluralistic liberal democracies, the state can only have legitimate authority to ensure the basic interests of children if empirical claims about what does or does not contribute to health and well-being are truly independent and devoid of commitments to specific worldviews. Moreover, given that this authority may imply overruling parents' choices, judgments about the basic interests of children should be based on the best possible biomedical evidence. Hence, as far as the contribution of vaccination to a child's health is concerned, democratic governments will make decisions by appealing to the state of scientific knowledge about vaccination and not to anthroposophist or other worldviews. Given that there is a broad scientific consensus that diseases like measles, polio, and pertussis can have very serious—lethal or permanently disabling—complications and that vaccinations against these infections are effective and safe, it is reasonable to hold that such vaccinations do indeed protect a basic interest of each child.

This argument provides an answer to the question posed in the last section: under which circumstances is the protection of the child's basic interests a ground for the government to override the rights of parents to

follow their (deeply felt) desire not to vaccinate? Even though parental prerogative is the most plausible starting point for this discussion, it is never an absolute principle. The doctrine of *parens patriae* holds that the state has its own responsibility to ensure that the basic interests of all children are secured. Its application in a specific case may be debatable, but the concept of *parens patriae* itself is not suspect in the least (Reiss, 2015, p. 3). At the end of the day, the state has a responsibility to safeguard each child's basic interests, including the interest of being free from preventable diseases. The child's basic interests define a *harm threshold* that sets limits on the freedom of parents to raise their children according to their conception of the good life. The harm threshold thus functions as an emergency brake on the parental prerogative, and this is especially the case if there is an avoidable risk of serious long-term or permanent injury or death (Dawson, 2005, p. 78).

This conclusion is in line with—*and endorses*—a central principle of modern constitutional thought, which is that the state must have the ultimate *Kompetenz–Kompetenz*. This is the competence to rule as to the extent of its own competence on when this is contested and, thus, to determine the respective areas of competence of natural persons and associations within its jurisdiction (Laborde, 2017, pp. 160–196). The state has the competence to determine the respective areas of competence of natural persons and associations within its jurisdiction. It is the state that provides parents with the legal right to the freedom of thought, conscience, and religion and the subsequent parental prerogative to raise their children in line with their ideas of what is good for their child. However, it is also the state that determines *the limits* of these fundamental rights and freedoms, especially when they clash with other fundamental rights and freedoms—including the rights of children to have their basic interests protected. Only governmental agencies can unilaterally determine the range and limits of the rights and duties of (associations of) citizens within their jurisdiction (Laborde, 2017, pp. 160–196). In summary, the state has the ultimate competence to employ the harm threshold as an emergency brake on parental prerogative when the basic interests of children are (about to be) harmed. The next question, regarding in which circumstances the government should be pulling this emergency brake, will be answered in subsequent sections.

5.4 The Harm Threshold and Refusal of Blood Transfusion

Let us take stock: parents have the primary prerogative in the upbringing of their children and in ensuring that their children's basic interests and best interests are taken care of. At the same time, the state never fully relinquishes final authority over a child's basic interests. It employs a harm threshold, leaving most choices concerning child-rearing to parents, and only intervenes if it is clear that a child's basic interests are about to be harmed. Let's explore a well-known problem in clinical ethics to elucidate how this harm threshold works in real-life cases, before getting back to vaccination. A commonly discussed case, both in medical ethics and law, is about Jehovah's Witnesses refusing blood transfusion. Jehovah's Witnesses see blood transfusions as a violation of certain passages in the Bible (e.g., Acts 15:20 and 15:28–29) that call for "abstaining from blood." In modern medicine, an adult person's decision to reject a (medically necessary) blood transfusion will often be respected. As argued in section 3.6, the right to bodily integrity makes it almost impossible to override a competent person's choice to refuse medical treatment. However, if it is about blood transfusion for a young child (e.g., a newborn with rhesus disease), the story will be different. Rhesus disease (also known as hemolytic disease) is a condition where antibodies in a pregnant woman's blood destroy her baby's blood cells. In severe cases, a newborn baby will need a blood transfusion to survive. Courts in liberal democracies recognize parental autonomy in medical decisions but "additionally recognize that these rights are not absolute and exist only to promote the welfare of children." (Wolley, 2005, p. 715). In situations where doctors or other care providers consider the medical treatment necessary because of a clear and present danger of severe harm, they cannot simply accept a refusal of permission by parents. Western legal systems address parental refusal of blood transfusions by requiring doctors to notify the judicial authorities. These authorities may override parents' wishes about treatment of their child or even temporarily remove their parental rights (Conti et al., 2018, p. 102) to ensure that the child will be given blood.

This provides a good explanation of how the harm threshold works. In normal health care contexts, physicians will not treat children without their parents' permission, and they will support parents to come to a decision that is in the best interests of their child. Health care providers and parents will

often jointly decide what is best. Ultimately, parents have wide discretion to observe their child's best interests and make (medical) decisions for their child, and if there is not a complete consensus between doctors and parents about which of several treatment options is preferred, physicians will normally defer to the parents' judgment. Yet parents do not have an absolute right to refuse medical treatment, and if physicians are convinced that refusal will be harmful for the child, for example, because there is a risk of death or permanent disability, they should diverge from the parents' view of the best interests of the child. The fact that parents have religious reasons for their refusal does not make a difference in such a case (Wolley, 2005, p. 716). Physicians can start a legal procedure and ask the judge for permission to administer medical treatment. The case of a Jehovah's Witness rhesus baby is relatively straightforward because blood transfusion is a curative medical intervention that is a necessary life-saving response to an imminent lethal risk. If the harm threshold is surpassed, the state has the ultimate authority to determine the limits of parental authority and the statutory legitimacy to override parental choices. But, as just argued, this is an emergency-break procedure, which is applied only in exceptional situations. One can think of many medical procedures that, although important for a child's current and future health, do not surpass this harm threshold. Especially in the case of preventive care, it is not obvious that the risks to be prevented are great enough to warrant restricting parental autonomy. This is not to say that such prevention is unimportant, but if enforcing prevention involves overriding parental choice, this is only clearly justified when there is an imminent threat of severe harm.

5.5 Is Vaccination a Basic Interest?

The state has a responsibility to observe basic rights of children, and in extreme cases, this may imply that choices of parents are overruled. Blood transfusion for Jehovah's Witness babies with rhesus disease is a clear case. But can immunization be considered analogously? Are vaccinations to be considered as protecting a basic interest of children, and if so, does that imply that public health authorities (possibly via a court order) are justified in setting aside the concerns of parents who would refuse immunization for their child?

Most immunizations, like many other forms of medical treatment, are indeed concerned with a *basic* interest, that is, being protected against

serious (potentially lethal or disabling) diseases. Of course, parents may have different views of the seriousness of those diseases or the safety of the procedure; even if they acknowledge that adverse effects are rare, they may fear that their child will be unlucky in this respect. People who endorse an anthroposophist view of life often see "childhood diseases" like measles or pertussis as a meaningful step in child development, and vaccinations in their view do not optimally contribute to a child's well-being. This shows how empirical claims about what does or does not contribute to health can be embedded in metaphysical assumptions or specific conceptions of what the good life consists of. Such assumptions are inevitable in any comprehensive idea of what determines a person's (i.e., a child's) best interest. However, we are not concerned with judgments about *what is best for children* that allow for strong commitments to a specific idea of the good life but with *basic interests* that apply to any person—regardless of their (parents') religion or conception of the good life. In a democratic, pluralistic state, the government can only have legitimate authority to ensure the basic interests of children if it can ground claims about the safety and effectiveness of interventions on sound and uncontroversial scientific evidence and state-of-the-art medical practice. Given that there is a very broad scientific consensus that diseases like measles, polio, and pertussis can have very serious—lethal or permanently disabling—complications and that vaccinations against these infections are effective and safe, it is reasonable to hold that such vaccinations do indeed protect a basic interest of each child.

Yet this claim—that common childhood immunizations protect a child's *basic* interest—does not necessarily imply that immunizations can also be enforced against the will of parents. Exploring the analogy with the Jehovah's Witness blood transfusion case is, again, instructive. What makes that case exceptional is that it involves a *necessary* response to an *imminent*, *life-threatening* risk. Childhood immunization programs do protect against disease that can be life threatening or disabling, but compared to the blood transfusion case, the risk is, at least in normal times, much, much smaller. Immunization offers protection if the person being vaccinated will be exposed to a pathogen like measles, but thanks to successful collective immunization programs, many people may never be exposed to that pathogen.

There are cases in which immunization offers the only genuinely effective protection against an imminent and serious threat—namely, when an unvaccinated child has been exposed to a potentially lethal or disabling

pathogen such as measles or hepatitis B. In such a case, prophylactic immunization given within a couple of days may prevent infection or prevent the most severe symptoms. There are different forms of postexposure prophylaxis (passive immunization by administering immunoglobin or active immunization by administering a regular vaccine), but both can be considered effective responses to an imminent, serious threat to a child's life and health. Prophylactic immunization after exposure to a pathogen thus has some of the central features of the Jehovah's Witness blood transfusion case, which supports seeing it as protecting a child's basic interest, and thus also as an intervention that public health authorities could enforce against the will of parents. Arguably, the health of a rhesus baby in need of blood transfusion is still much more severely threatened than the health of an unvaccinated child who is exposed to measles. Nevertheless, unprotected exposure to a lethal pathogen is thwarting a basic interest, and this implies that the state should interfere immediately if effective protection is available.[7]

Note that in such a case, *forced vaccination* would be necessary, which is the most intrusive measure in our categorization of interventions (section 2.4), involving the clearest and strictest limitation of parental autonomy. It completely bypasses parental discretion: parental autonomy is not merely constrained; it is eliminated. Most discussions about setting limits on parental freedom to refuse vaccination are not, however, about forced vaccination but about policies that set vaccination as a requirement for school entry, or for child benefits, or that make vaccination refusal a criminal offense. Such policies, even though they are mandatory or compulsory, still leave opportunities for parents to be exempted or to otherwise avoid vaccination of their child. For that reason, these less intrusive alternatives will be irrelevant for a government that has a *pro tanto* obligation *to secure* protection and thus enforce vaccination as a basic interest for a child at immediate risk.

Our conclusion is that childhood immunization does protect the basic interests of children that the state must guarantee, but that, in normal times, the risks of nonvaccination are too remote to warrant forced vaccination against the will of parents. The analogy with the blood transfusion case does not make sense in the case of routine immunization programs. It only makes sense in cases of *postexposure prophylactic* immunization or during an outbreak of a lethal disease where exposure cannot be avoided. Outside the context of an immediate and possibly lethal threat of infection, there is no place for forced vaccinations. This is not only because in

normal circumstances, the risk for each individual child will be remote, but also because there is an alternative way for the government to protect each child's basic interests in normal conditions: by maintaining adequate collective protection via high vaccination rates.

Our analysis in terms of basic and best interests of children thus offers additional support for policies that aim at group-level protection. Maintaining such group protection is necessary for the state to fulfill a key responsibility: to secure basic interests of all children. In circumstances of robust herd immunity, parents do not expose their own child to an unacceptable risk if they refuse vaccination, and then *forced* immunization would be unwarranted. However, they do undermine the collective endeavor to maintain the group-level protection that is benefiting their child as well. Hence, as argued already in the previous chapter, vaccination refusal does fall within the scope of the harm principle, and this offers support for mandatory or compulsory programs.

5.6 Basic and Best Interests in Childhood Immunization: A Conclusion

In this chapter, we have argued that in most cases, most of the time, it is parents and not the state who have the authority to determine what is in the best interests of their young children, and they have the freedom and responsibility to act in line with their view of what is best for their child. Parents' views on this matter can, however, conflict with their child's *basic* interests, and the protection of basic interests is ultimately a responsibility for the state. Basic interests are those interests that are deemed necessary for a very broad range of opportunities in current and later life—and hence are consistent with and necessary for a broad variety of conceptions of the good life. They include interests such as being protected from serious diseases, being adequately nourished, growing up in a safe environment in which caring relations can flourish, and having access to a good-quality education.

Threats to a child's basic interests are always a sufficient reason for the state to intervene, to protect the child or enable parents to do so. But if a basic interest of a child is at stake due to the choices or actions of the parents themselves, the state will be reluctant to intervene in family life and overrule parental decisions. This is because parental autonomy and freedom of religion or belief are core values in a democratic society. Overruling these values requires a thorough weighing up of all competing interests, taking all

contextual factors into account, such as the magnitude of the risk, the nature of the intervention, and the availability of alternative measures to protect the child.

In the case of Jehovah's Witnesses who refuse medically necessary blood transfusions for their newborn child, legal intervention is justified (temporarily) to remove the child from the custody of parents so that they can receive the treatment they need. The treatment is necessary to avert a present danger in the form of a life-threatening disease, so this is a relatively clear case. Vaccination is more complex because it is a preventive intervention that takes away a risk that is often remote. Nevertheless, we claim that the analogy with parents refusing blood transfusion can largely be upheld if parents refuse vaccination of their child who is at *immediate* risk of infection with a *serious* (life-threatening or disabling) disease. Even though the risk will be still much smaller in the extreme vaccination case compared to the blood transfusion case, we hold that it passes the harm threshold and thus warrants government force.

Hence, we conclude that there are cases, probably only during an outbreak, where the state is ethically justified in overruling parental refusal and enforcing immunization of a young child. This can best be done by a court ruling relating to individual children rather than a sweeping policy drafted by public health care authorities, ensuring that there are relevant checks and balances and a fair procedure. Outside the context of an outbreak, forced vaccination against infectious diseases is difficult to justify—not only because the risk of infection as such will be much smaller but also because health authorities will have other, more proportionate measures that they can implement to protect the basic interests of all children: a mandatory or compulsory vaccination program that is sufficiently coercive—but not more than necessary—to maintain high immunization rates.

Inducing Immunity?

Justifying Immunization Policies in Times of Vaccine Hesitancy

By: Roland Pierik, Marcel Verweij

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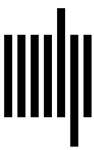

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