Is immunisation child protection?

The Lancet’s Series entitled new decade of vaccines shows the great opportunities for, and many challenges that face, successful development and implementation of vaccines in the coming decades. The Series emphasises recent advances in biomedical sciences, particularly molecular microbiology, immunology, and genetics. But the biggest hurdle to realisation of this potential could instead relate to failure of parental acceptance of safe and effective vaccination.

Refusal of parents to vaccinate their children is an example of the conflict between the best interests of children and the autonomy and interests of parents. It raises the issue of the extent to which state authority can interfere in private family life to protect children. This conflict can be approached from different ethical perspectives and theories. However, the basic underlying principle is that children’s interests need to be protected. Historically, children were viewed as the property of their parents, but they are now recognised as vulnerable and dependent individuals who are in need of protection through instruments such as children’s rights.

Liberal democracies are characterised by neutrality to different conceptions of the good life, or citizens’ own interests. That is, every adult enjoys freedom to form and act on their own conception of what is best for their life. This freedom spills over into parenting, in which parents are afforded considerable freedom to rear their children according to their own values and conception of best interests. But, unlike adults, the freedom of young children is highly restricted because they are not competent and cannot autonomously accept risks to which they are exposed. Children should not be exposed to clear, direct, and substantial risks of harm. Thus parents are not ethically or legally permitted to refuse life-saving blood transfusions or medical procedures on the basis of their conception of what is best for their child. Any deviation from a widely accepted account of the interests of a child must be reasonable. High risk of death or serious illness is not reasonably in a child’s interests.

Notwithstanding important practical and ethical differences, some parallels can be drawn between immunisation and child protection. The first relates to communication. Child abuse and many vaccine-preventable infections are prevalent but are largely invisible or, at least, not widely known about. Hand in hand with this unawareness, there is a fundamental and widespread lack of understanding of these two areas of child welfare and their complexities. A consequence is that public opinion and related media communication in both areas tend to be dangerously polarised. In child protection, one hears about either disastrous failures of detection or allegedly false accusations of innocent parents or carers, both of which are very rare exceptions even assuming such reports are accurate. For vaccines, one hears unqualified celebrations of promise or success, or unfounded or anecdotal scare stories.

Emerging pressure groups and networks of highly motivated individuals—whose engagement and qualification to comment is often solely based on personal experiences and related grievances—can have a major influence on public commentary and even policy. Such groups have successfully captured the agenda on child protection through the media, the UK’s General Medical Council, the courts, and employers of health professionals through complaints procedures. Similarly, antivaccine campaigners have achieved prominence and influence in the media and political debate. Although mainstream trends promoting public consultation and professional accountability give some legitimacy to such individuals and groups, such public debate can become distorted and harmful to the interests of children. In particular, the fundamental difference between selective assembly of evidence in support of a firmly held belief, and construction of a hypothesis that is tested through experiment and systematic observation, is often overlooked and widely misunderstood by both the public and commentators.

The second parallel relates to the role of parents in protection of their children’s health and welfare. In general, society rightly entrusts the welfare of children—the future society—to parents, who have to bear the burden of care for bringing up children. Usually, parents are highly motivated to protect their children’s welfare and maximise their opportunities, and can be relied on to make sensible decisions. Moreover, they have privileged access to their child’s circumstances, social networks, and living conditions. But as vulnerable and dependent individuals, children’s rights have to be protected ultimately by the state in its parens patriae role. In some situations, the best interests of the child diverge from
the views and actions of the parents, unless an extreme version of ethical relativism is accepted. In the case of a violent or neglectful parent, well defined mechanisms are in place to protect the child. But should the same principle pertain to parents who refuse immunisation and thereby fail to take the necessary action to protect their children from preventable and potentially serious infection? Does the failure to immunise a child against a serious infection with a safe vaccine constitute child abuse? Should the state intervene to ensure children are protected from serious infectious diseases?

The analogy with child abuse is clear when the imminent risk to the child is high without intervention—eg, a child bitten by a rabid dog or a newborn baby of a woman infected with hepatitis B. In such cases, the health-care profession has a very strong case to ask a court to mandate intervention when parents refuse immunisation. However, the analogy becomes complicated for most common childhood infectious diseases, such as measles, diphtheria, and pertussis. Protection from infections is something children should reasonably be able to expect as a general right. However, in countries where particular infections are rare—often because of widespread immunisation—the actual risk of remaining unimmunised might be quite small or even non-existent. In this situation, parents expose their children to a very small risk by refusing vaccination. The situation can even arise—as it did with oral poliovirus immunisation in the UK for a period before 2006—in which the risks of immunisation, although extremely small, exceed those of refusing the vaccine, provided that only a few individuals remain unimmunised. Generally, immunisation not only protects the health of the child, but also contributes to protection of all children. When enough parents opt out from immunisation of their children, infections increase in unimmunised or otherwise unprotected individuals, as is occurring with measles throughout western Europe.

In this situation, the social contract between the state and the parent, on behalf of the child, is also a contract about the common good. Although an abusing parent should obviously be prevented from harming or neglecting their child, the ethical argument to require a parent to have their child immunised in the context of high herd protection is weaker and less clear. It has an element of altruism and beneficence. Paradoxically, as more parents refuse, compulsion to immunise becomes easier because the risk to individual children rises. Thus, in cases of low herd protection, the state has a compelling reason to require immunisation with safe vaccination against serious infectious illness because the risks to children of being unvaccinated are substantially increased. In this case, immunisation is a matter of child protection and the state has to secure the interests of children. An example could be a highly virulent pandemic strain of influenza. However, events of the H1N1 influenza pandemic in 2009 suggest that the threat of even moderately virulent influenza quickly induces widespread demands for vaccination, indicating that the evident threat of serious disease makes compulsion unnecessary.

The third parallel relates to the need for protection of unvaccinated children in an epidemic in which demand for vaccination is insufficient, despite the fact that vaccination is safe. Parents are not legally entitled to refuse medical treatments which are substantially beneficial for their children from preventable and potentially serious infections. An example could be a highly virulent pandemic strain of influenza. However, events of the H1N1 influenza pandemic in 2009 suggest that the threat of even moderately virulent influenza quickly induces widespread demands for vaccination, indicating that the evident threat of serious disease makes compulsion unnecessary.

Faced with the sometimes conflicting values of parental liberty and the need to protect children from infectious disease, where should we turn for guidance? Perhaps to parents. Again the comparison with child protection is instructive. In child protection, the number of parents who adequately care for their children is irrelevant to a child at risk. However, for infectious
diseases transmitted between human beings, the more parents who protect their children through vaccination, the higher the herd protection and the lower the risk for any non-immune children. Of the many parents who have their children fully and promptly immunised, the proportion who are fully aware of the broad benefits of immunisation is not precisely known. However, most parents actively support childhood immunisation, and when the opportunity arises to participate in clinical trials, which are essential for the development and licensure of new vaccines for children, there are always parents prepared to volunteer their children to participate once full information has been provided. Therefore the kind of parental altruism that society needs to make such public health programmes work and survive does exist. The challenge remains to harness this goodwill to protect all children.

Just as we owe it to our children and their children not to destroy the environment in which they will live, we also owe it to them to pass on an environment in which they can be unexposed to the entirely avoidable risks of many infectious diseases. The moral imperative is clear and the question is not whether to do it, but how. For immunisation, unlike child protection, vaccination of enough individuals can lead to protection for all. This is a unique opportunity to work together for the common good.

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3 Bridson JM, Samuels M, Speight N, Williams C. Open letter to Professor Peter Rubin, Chair of the General Medical Council. BMJ 2010; 341: c3884.