PEDIATRICS PERSPECTIVES

Reasons to Accept Vaccine Refusers in Primary Care

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Vaccine refusal forces us to confront tensions between many values, including scientific expertise, parental rights, children's best interests, social responsibility, public trust, and community health. Recent outbreaks of vaccine-preventable and emerging infectious diseases have amplified these issues. The prospect of a coronavirus disease 2019 vaccine signals even more friction on the horizon. In this contentious sociopolitical landscape, it is therefore more important than ever for clinicians to identify ethically justified responses to vaccine refusal.

The American Academy of Pediatrics (AAP) says dismissing families who continue to refuse vaccines is an "acceptable option,"[1] but some practices have gone further by not accepting vaccine refusers as patients at all.[2,3] The phenomenon of nonacceptance has been underexplored; in both empirical studies and ethics analyses, researchers largely focus on dismissal.[4–7] In this article, we first criticize arguments for nonacceptance that invoke a supposed right to choose one's patients. We then argue that nonacceptance is problematic because (1) some of its motivations are intrinsically immoral, (2) it does not appear to accomplish some of its goals, and (3) even when nonacceptance does accomplish its goals, it fails to appropriately balance the various values it implicates. Throughout the article, we engage with the existing ethics literature about dismissal and conclude that even if dismissal is sometimes justifiable, nonacceptance is not.

A RIGHT TO CHOOSE ONE'S PATIENTS?

Some may argue that nonacceptance is ethically justified because they believe the clinical relationship is fundamentally a free association between clinicians and patients, as the American Medical Association Code of Medical Ethics appears to assert.[8] If clinicians have a right to choose their patients, then they may seem to have moral permission to decline to accept vaccine-refusing families. On this view, nonacceptance is ethical because, except in emergencies, clinicians have no moral responsibility to treat people who are not their patients.

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However, the freedom to choose one's patients does not mean all such exercises of this choice are ethical. Instead, clinicians have an ethical obligation to use their professional autonomy for good reasons and to achieve good results. This distinction is consistent with how the American Medical Association Code of Medical Ethics (§1.1.2) further delimits permissible reasons for the rejection of potential patients: if patients demand medically inappropriate care, if a clinician could not provide patients competent care, or if accepting new patients would compromise care to existing patients.[8] Although one may argue that vaccine refusers demand medically inappropriate care, that is incorrect; they instead reject one kind of appropriate care. Vaccine refusers are therefore similar to others who reject some recommended treatments, such as parents who refuse the newborn screen. Additionally, there is nothing about accepting vaccine-refusing families into one's practice that prevents clinicians from providing competent care when it comes to everything other than immunization. We will later address the worry that accepting vaccine refusers into one's practice undermines clinicians' ability to care for other patients. We begin with a critique of some motivations for nonacceptance.

MOTIVATIONS FOR NONACCEPTANCE

Several potential motivations for not accepting vaccine refusers are intrinsically wrong. For instance, it is wrong for clinicians not to accept vaccine refusers because they want only compliant families. This motivation is excessively paternalistic and inconsistent with patient- and family-centered care, which requires a willingness to collaborate and compromise to find treatments that are consistent with family values and preferences.[9] This motivation is also inconsistent with the values of openness and tolerance that should be promoted in the context of caring for members of diverse communities. Pediatric clinicians frequently allow families in their practices who do not fully comply with recommendations. For example, the fact that parents smoke in the home or provide unhealthy foods for their children is not commonly thought to be a reason to exclude them from pediatric practices.

In contrast to this inherently unjustifiable motivation, many motivations for nonacceptance may be permissible in themselves but fail to achieve the goals at which they aim. For instance, clinicians sometimes choose not to accept vaccine refusers to incentivize vaccination or to protect professional integrity. In the next section, we argue that not accepting vaccine refusers for these reasons is also not justifiable.

Incentivizing Vaccination

Some argue that the threat of dismissal can be leveraged to promote vaccine uptake.[10,11] Such threats are likely to be unethically coercive, particularly in communities with few pediatricians. But even if such threats were not coercive, the appropriateness of these threats hinges on whether there is good evidence that they promote vaccine uptake. Anecdotes aside, there is no empirical evidence that they do.[4] Furthermore, even if dismissal improved vaccine uptake, it seems less likely that nonacceptance would have the same effect because dismissal presents families with the prospect of losing an existing relationship, something that families who are only potential patients do not yet possess. Policies of nonacceptance seem to offer less leverage to incentivize vaccination than dismissal policies because a parent whose child has an existing relationship with a pediatric provider has more to lose than one who does not.

Defending Professional Integrity

Some clinicians assert that the dismissal of vaccine refusers is necessary to preserve professional integrity. Retaining vaccine refusers in one's practice, the argument goes, is tantamount to the approval of providing substandard care.[12] We agree that clinicians should uncompromisingly advocate for the highest standards of care. Accordingly, appeals to professional integrity make at least some sense in the context of dismissal because dismissing clinicians have presumably made good-faith attempts to persuade and educate vaccine refusers. They have advocated for the standard of care and thereby upheld their professional integrity. In contrast, clinicians who choose not to accept vaccine-refusing families have not attempted to persuade those families to vaccinate and thus have not advocated for the standard of care within the context of those families. Therefore, a commitment to professional integrity cannot count in favor of nonacceptance.

Along similar lines, one might defend dismissal or nonacceptance as a form of conscientious objection, a claim that deserves special attention in light of recent efforts to expand conscience protections in medicine.[13] Central to this argument is that clinicians not only have a duty of nonmaleficence, which prohibits offering treatments they believe are harmful, but they also have a right to refuse to provide interventions they believe are ethically wrong. Yet including vaccine-refusing families in one's practice does not involve offering treatments that are harmful or providing interventions that one believes are ethically wrong. Rather, it involves honoring a parent's refusal of a beneficial intervention, at least for a period of time. Therefore, we

argue that the concept of conscientious objection supports neither dismissal nor nonacceptance of vaccine-refusing families.

TRUST AND NONACCEPTANCE

Some clinicians may dismiss vaccine refusers because they believe parents and clinicians cannot trust each other about other issues in pediatric care once they reach an impasse about vaccines.[10,12] This conclusion is supported by the AAP.[1,7] We argue, however, that although worries about a breakdown in trust may sometimes justify dismissal, they do not justify nonacceptance. There is no evidence that all vaccine-refusing families systematically distrust pediatric clinicians. This means that clinicians often do not know in advance, on the basis of vaccine refusal alone, that a family will not trust them. Furthermore, there is concern that dismissal may actually undermine the trust families place in a particular clinician or in the medical profession,[7,14] a concern that would also apply to nonacceptance.

NONACCEPTANCE FAILS TO APPROPRIATELY BALANCE COMPETING GOALS

We have so far contended that several motivations for not accepting vaccine refusers are either intrinsically wrong or cannot accomplish their goals. There are, however, some laudable goals that nonacceptance could possibly promote, including reducing the risks to other patients and the burden on clinicians. We argue, however, that nonacceptance is not justifiable, even if it accomplishes these goals, because it unacceptably undermines other central competing goals, including the health of the child, public health, and solidarity with one's colleagues.

Dismissal is occasionally defended on the grounds that allowing families to remain in one's practice after continued refusal of vaccines imposes unacceptably high risks of infection on other patients and excessive legal liabilities, financial risks, and psychological burden on clinicians.[12] The evidence for these claims remains inconclusive.[3,7] However, even if there were sufficient evidence, we must also ask whether nonacceptance appropriately balances the interests of other patients and the clinician against other ethical goals that clinicians must promote. There are at least 3 reasons to think that nonacceptance does not achieve this balance.

First, a precautionary principle, in which clinicians should never admit patients who could increase risks to themselves or other patients, could justify nonacceptance, but this principle provides an unreasonable standard for deciding when to accept families. Many kinds of patients can be risky (eg, patients with active infections or recent histories of exposure), and it would be unreasonable for a practice to refuse to accept all such patients. Therefore, we maintain that a precautionary principle is not an appropriate way to balance the values involved in decisions about whether to accept vaccine refusers.

Second, a commitment to exclude children whose parents make bad choices could support nonacceptance, but this principle is likewise unjustifiable. Many child patients have parents who make bad decisions, such as children with obesity whose parents are noncompliant with clinical guidance about nutrition. It is taken for granted within the profession that these children should not be denied care, even if they are more burdensome and even if their parents continue to refuse to change their minds. Therefore, a principle of excluding patients who are riskier or more burdensome because their parents make bad choices does not well balance the values involved in decisions about whether to accept vaccine refusers.

Third, nonacceptance is inconsistent with a duty to attempt to change vaccine-refusing families' minds. Vaccine refusal is a modifiable behavior[15] with several evidence-based strategies available for increasing vaccine acceptance within the doctor-parent relationship.[16] Clinicians cannot know ahead of time which families might respond to their efforts to promote, educate, and persuade.[17] The importance of the child patient's health, the public's health, and solidarity to other pediatric professionals all support making such efforts.

Education and persuasion efforts may promote an unvaccinated child's well-being, both because they may change parents' minds about vaccines but also because the child patient will continue to receive preventive care. Moreover, efforts to educate and persuade may be good for the public's health, both because children may eventually get some vaccines but also because keeping undervaccinated children in one's practice prevents many more of them from clustering in only a few practices, which contributes to outbreaks.[18,19] Finally, efforts to educate and persuade are a means by which clinicians can bear their share of the burdens associated with caring for vaccine-refusing families.[7,20] In contrast, a clinician who dismisses or does not accept vaccine-refusing families violates professional solidarity by transferring the burdens associated with that family to colleagues.

Ultimately, although all of these concerns about children's well-being, public health, and solidarity with colleagues count against dismissal, they weigh even more heavily against nonacceptance. A clinician who dismisses patients after months or years of continued vaccine refusal has absorbed a share of the burdens associated with treating these

families, and they have made at least some effort to promote the health of the child and to protect the health of the community. In contrast, clinicians who do not even accept vaccine refusers defer these burdens entirely to others and do not fulfill their responsibility to children and the broader community.

CONCLUSIONS

On first glance, the dismissal and nonacceptance of vaccine refusers may seem to be morally equivalent practices. In turn, some may conclude that the AAP's recent permission to dismiss vaccine refusers grants tacit permission not to accept such families. But dismissal and nonacceptance are not ethically equivalent practices. Even if dismissal were sometimes an ethically acceptable option, wholesale nonacceptance of these families is not.

ABBREVIATION

AAP: American Academy of Pediatrics

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