What to do with patients who don't vaccinate

Dr. P. is a pediatrician in independent practice in greater Minnesota. She has experienced an influx of parents refusing vaccinations for their children; she estimates that 65 percent of her patients have received or are on schedule to receive all indicated vaccines, 30 percent have not received all or some indicated vaccines due to refusal by their parents, and 5 percent are partially or fully unvaccinated for other reasons. Dr. P. is increasingly concerned that by continuing to provide care for such a large population of unvaccinated patients, she is placing all of her patients at risk of contracting a vaccine-preventable illness. She is considering expelling from her practice patients whose parents either refuse indicated vaccines for their children after two separate opportunities to consent or who fail to abide by a recommended catch-up schedule. If either applies, she would decline to continue treating the patient and refer the family to another physician. Assuming it is legal, is it ethically permissible for Dr. P to institute this policy?

Expel them—in a focused way

FRANK RHAME, MD

The anti-vaccine movement is extremely frustrating. Vaccination is very safe, highly effective and one of the most important health benefits humanity has devised. Vaccine refusal is harmful to one's self and, for most vaccines, to others. Misguided anti-vaccination views are directly responsible for recent measles outbreaks in the United States, including in Minnesota.

In 2016, the American Academy of Pediatrics seemed open to dismissal of non-compliant families: "the individual pediatrician may consider dismissal of families who refuse vaccination as an acceptable option." The AAP presented caveats, counter arguments and constraints, but did not condemn the practice (Pediatrics 2016;138:e20162146).

I find all these discussions to be inadequate because they are not explicit. For instance, none of them define lack of vaccination. It would not be reasonable to dismiss a patient because hepatitis A immunization was given one month late or if only the poliovirus vaccination was omitted. None of these analyses consider the issue by vaccine type. We have no poliovirus and reintroduction is very unlikely. Hepatitis A, hepatitis B, rotavirus and human papillomavirus are unlikely to be transmitted in a pediatric waiting room. Neisseria meningitidis, Haemophilus influenzae type b and Streptococcus pneumoniae are transmissible, but only inefficiently. Lack of influenza vaccination is common and exposure in the community is pervasive during outbreaks; threat of dismissal is unwarranted. Pertussis is a difficult case: it is highly transmissible but its transmission is by droplet spread and continuous presence in the community is inevitable because immunity declines in adulthood (herd immunity doesn't happen).

Waiting room hazard can be narrowed to four viruses: varicella, measles, mumps and rubella, all of which can spread by the air-

Keep them—and keep persuading

ROBERT M. JACOBSON, MD

Medical practices should not exclude or dismiss patients who choose not to vaccinate. I appeal to three principles that guide medical ethics: beneficence, justice and respect for personhood.

Beneficence: Let's first deal with the special case of the child, who cannot obtain routine vaccination in most cases without parental permission. Norman Fost eloquently states that when considering the ethical concerns of a child it is the needs of the child and not the parents or others that should be the primary consideration. How does it benefit the child to exclude that child from one's practice because of the willful decision of the parent? I argue that persistent, strong recommendations made by the clinician to parents who have declined vaccines in the past can overcome that resistance. That's from both personal experience and empirical data (e.g., Opel, 2013). Routine vaccination provides a benefit that has no reasonable alternative, so excluding the family from your practice is tantamount to withholding that benefit. The family could go to another practice where the clinician may succeed in vaccinating, but this is unlikely given the parent's current inclinations. Kant teaches that if one holds one's rule is moral, one should envision applying that rule categorically. This is to say that if you believe your practice can exclude such patients, all medical practices should be able to do so. On the basis of the principle of beneficence alone, we should keep this child in our practice.

In the case of adults who refuse to receive vaccines themselves, I believe exclusion for similar reasons would put those adults at harm—and excluding these adults from the opportunity to eventually receive the vaccines may put others at harm.

Justice: Having unvaccinated patients in your office rooms, waiting rooms, etc. puts other patients at risk. Given the high

Expel them *(continued)*

borne route. The presence of unvaccinated children in the waiting room is inevitable, since vaccination for MMR or varicella generally doesn't begin until 12 months. Most of the time most of these viruses aren't circulating in the community, so unfocused time-unlimited dismissals seem unwarranted.

Clinicians could post a warning that when measles, mumps, rubella or varicella are circulating in the clinic's catchment area, anyone not up-to-date on vaccination for the particular circulating virus will be denied service for elective problems until two times the upper limit of the incubation period from the last recognized case in the community. For unvaccinated patients with acute illness, a phone discussion with the practice would be required. If they really need to be seen, they must accept mitigating arrangements, such as being the last patient in the day.

This policy, which I believe is ethical, has flaws. There is no protection until after the first case in the community is recognized. The clinician has practical difficulties in learning about recognized cases in the community. The definition of the catchment area can be difficult. The potential legal difficulty associated with general dismissal (the need to provide emergency care for a month and assist in finding an alternate clinician) should not arise. My proposal is focused in time and circumstance, rather than a general dismissal of all unvaccinated patients.

Frank Rhame, MD, is an infectious disease specialist and professor of Medicine at the University of Minnesota Medical School.

Keep them *(continued)*

likelihood of an unvaccinated adult developing influenza and arriving at your office for care, this is not a trivial concern. Is it fair to the other patients? Office policies regarding patients coughing and sneezing can reduce the risk to other patients. Excluding nonvaccinating adults from your office still leaves the larger community at risk from those adults. By retaining them as patients and continuing to use every visit to persist in strong recommendations to vaccinate, you have a real opportunity to persuade them and then protect both the patients in your offices and the larger community.

Respect for personhood: The adult patient, unlike the child or minor adolescent, has tacitly appealed to the right to self-determination. In the end, shouldn't each competent, informed adult have the right to choose how to manage their health? I am not requiring adult patients to receive vaccines and I am not forcing them to accept vaccines simply to remain in my practice. This supports my respect for their personhood and self-determination—and I am able to persist in my strong recommendations for vaccination with them.

Robert M. Jacobson, MD, is a primary care clinician and professor of Pediatrics at Mayo Clinic.