Of Vaccines, Mandates, and Freedoms

An Historical and Ethical Exploration

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The recent events around COVID and the vaccine mandate have understandably resulted in many questions from NZAP members to me and other Council members. Considering those questions prompted me to research the historical background to epidemics, vaccines, and mandates. Council felt it would be helpful to share this material with members to both assist them in understanding Council's position and in making their own ethically informed decisions in these difficult times.

Some of the current arguments circulating about mandates frame them as unprecedented government overreach. Mandating health treatments is not something governments normally do, and such extraordinary measures do require extraordinary justifications.

Mandatory vaccination is unique in biomedical ethics as the only instance in which people are asked to accept a treatment, potentially against their free will, in the service of the public good. Alongside that, vaccine passports are politically unique in imposing social restrictions on people who refuse it.

Is this situation unique and unprecedented?

The Historical Context: Epidemics and Vaccines

The idea that all these issues are new is a decidedly ahistorical view. Outbreaks of epidemic disease have long vexed and frightened human populations and had a marked effect on human history—medically, socially, and politically (McNeil, 1976; Diamond, 1997).

The arguments around epidemics, vaccines, mandates, and freedom have a long history in human affairs, dating back almost 250 years. The disease in question then was smallpox which had a 30% mortality rate and left survivors permanently scarred with small facial pockmarks (hence the name) and sometimes blind. Smallpox had been terrifying humanity since the 6th century.

Variolation was a medical technique developed around 1720 which exposed people to smallpox in a cut on their arm hoping that a minor skin infection would give them immunity with less risk of killing, scarring, or blinding them. When Prince Louis XV of France died of smallpox in a 1774 outbreak, his successor Louis XVI mandated the still distrusted practice of variolation for his entire royal line. They all survived and variolation even became fashionable and popular in French society.

The next major medical innovation against smallpox came in 1796 when Jenner developed his process of vaccination by exposure to cowpox (Jenner, 1801). It was safer than variolation which could still kill you and spread smallpox if it

was not done properly (or you were unlucky) leading the UK government to ban the older technique in 1840. In 1853 the UK government put in place the first nationwide vaccine mandate for all infants.

Anti-vaccine and anti-mandate groups mobilised and began protesting. Much of the now familiar strains of misinformation emerged too. Some claimed that Jenner's new technique was experimental, untested, and unsafe. Others considered it to be ungodly and unbiblical. There were no claims about RNA or DNA since they were not discovered until 1869. Nevertheless, some people claimed that receiving the vaccine could change people into cows.

A cartoon by James Gillray titled 'The Cow-Pock' from 1802.

Many of the arguments against mandates were expressed too. Some wanted the older kind of inoculation, even though it was more dangerous. Others favoured natural immunity and wanted complete bodily autonomy rather than state intervention (Wolfe & Sharp, 2002).

However, as we see with governments today, the governments of the 1800s did not accept these arguments. Most of our ancestors rolled up their sleeves and got their dot, as most of us have today. The UK vaccine mandate succeeded in stemming repeated smallpox outbreaks as did the many mandates that followed it in other countries (Milward, 2019).

Almost 150 years later, in 1980, the World Health Organization was able to declare smallpox *eradicated*. There is also polio which was eradicated in the developed world in 1979 and we are closing in on world eradication now. Polio vaccination did not generate the same resistance that smallpox vaccination had but there were still some who vigorously opposed it, such as cosmetics magnate Duon Miller.

That is two horrific diseases that no longer stalk our children, thanks to broad public support for mandatory vaccination and the tireless efforts of innumerable health professionals. So how do medical professionals and ethicists justify vaccine mandates, then and now?

The Historical Context: Freedom and Mandates

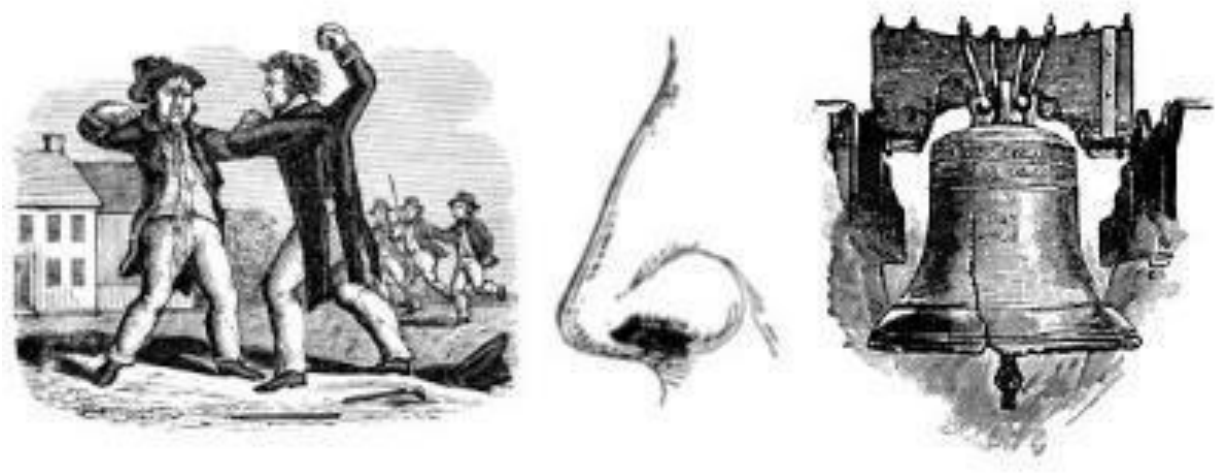
In the mid to late 1700s, a pair of closely related political philosophies was ascendent which placed personal autonomy (individual freedom) as central—classical liberalism and libertarianism—and these ideas formed a strong basis for the arguments against vaccination.

Both were partly informed by concerns about theocratic monarchs and tyrannical dictators who often ruled by claims of Divine Right backed by state violence and the oppression of dissent. These philosophies are characterised by a focus on ideals of self-ownership, a deep distrust of all forms of centralised power, strong arguments against coercion for personal or public good, and, for some, considerable suspicion about the very concept of 'the public good'.

"Libertarians strongly value individual freedom and see this as justifying strong protections for individual freedom. Thus, libertarians insist that justice poses stringent limits to coercion. While people can be justifiably forced to do certain things (most obviously, to refrain from violating the rights of others) they cannot be coerced to serve the overall good of society, or even their own personal good."
(https://plato.stanford.edu/entries/libertarianism/, 2019)

The philosophy is often summarised by a quote attributed to English philosopher John Stuart Mill (1859), author of *On*

Liberty: "My freedom to swing my fist ends where your nose begins".



What is central to this aphorism is a strong view of bodily autonomy that extends to our visible physical boundary—it stops at each other's skin.

These philosophies reached their zenith around 1820, within the era of Hippocrates' Miasma theory which held that diseases (Black Death, Cholera, Typhoid, Malaria, etc.) emanated from rotting organic material producing 'bad air'. Notably, this predates the acceptance of the Germ Theory of Disease proved by Pasteur in 1860-1864.

Variolation had been practiced since 1720 but physicians did not know *why* or *how* it worked. The idea that you could harm others without physically striking them was counter to intuition and initially seen as an unwelcome and unjust restriction on personal liberty. Scientific advances have since clearly established that microbes and viruses we carry but cannot see

with the naked eye *can* and *do* cause considerable harm to others, even though *we* do not intend them to.

Modern Medicine and Biomedical Ethics

The Germ Theory of Disease is a cornerstone of modern medicine (Tulchinksy & Varavikova, 2014) and deeply informs biomedical ethics which are balanced on four pillars—beneficence, non-maleficence, justice, and autonomy (Beauchamp & Childress, 1979). Those four principles also underpin the NZAP code of ethics which adds interdependence (or relationship) as a fifth principle, further strengthening our commitment and connection to the well-being of others. While medical ethics considers "autonomy as first among equals" (Gillon, 2003, p. 310), it does *not* override the other principles, and this is central to the justification of vaccine mandates.

"Vaccination is unique among de facto mandatory requirements in the modern era, requiring individuals to accept the injection of a medicine or medicinal agent into their bodies, and it has provoked a spirited opposition" (Wolfe & Sharp, 2002, p. 432).

As mandates subordinate *private* autonomy to *public* beneficence, this overriding of personal and bodily autonomy rightly requires a very high threshold. Biomedical ethicists speak of four conditions which must be satisfied before mandatory vaccination is considered justified and ethical (Savulescu, 2021):

1. There is a grave threat to public health

2. The vaccine is safe and effective
3. Mandatory vaccination has a superior cost/benefit profile compared with other alternatives
4. The level of coercion is proportionate.

The scientific and ethical consensus is that these four conditions have been met (Gostin et al., 2020; Wynia et al., 2021).

The SARS-CoV2 pandemic is a grave threat to public health with over 5 million deaths and counting. Considerable evidence exists to support both the safety and effectiveness of the vaccines developed to combat it (Liu, et al., 2021). This is especially true of the mRNA vaccines which have a very low side-effect profile and 95% reductions in risk of serious illness and death as well as significantly reducing transmission.

The epidemiological consensus is that mandatory vaccination is superior to other control methods, particularly in the context of the highly aerosol transmissible Delta and Omicron variants for which masks, hygiene, social distancing, testing, and contact tracing are insufficient to prevent exponentially growing outbreaks.

Requiring vaccination for individuals in high-risk professions is considered proportionate. The recent inclusion of healthcare workers (such as psychotherapists) and teachers is due to both spending extended periods of time in close contact with others which heightens transmission risk, both from their clients and

pupils to them, and from them to their pupils and clients. The current medical consensus is that there is no other effective way to adequately protect children, the elderly, the immune-compromised, and vulnerable communities such as Māori and Pasifika, and the poor and disenfranchised from preventable death and serious illness other than mass vaccination, backed by mandates to ensure safe public access to essential health and other services.

For those who choose not to be vaccinated, the passport restrictions are intended to protect them and others they may interact with, by reducing their level of social contact as the virus patiently seeks out the unvaccinated. They also aim to reduce the impact on our limited public health resources (hospital beds, ICU facilities, etc.) as ethicists rightly note that it is unethical to limit individuals' access to medical care even though they may have acted in ways that increased risk to their own health and that of others.

Conclusion

Ethical decision-making is multi-faceted and often involves weighing up multiple conflicting factors and carefully considering differing perspectives. The NZAP code of ethics has a one-page decision making flowchart that offers a framework which may be helpful to members grappling with their own ethical decisions. In terms of acting within our code of ethics, clauses 1.1, 1.4, 1.8, 2.15, and 3.2 relate to safe legal practice regarding complying with health orders and clauses 2.2 and 2.6

relate to our expertise and that of other health professionals and the importance of only providing accurate health information and not misinformation.

I hope that this article helps members to understand the thinking that underpins Council's position on vaccination and the mandate for psychotherapists, and that it also offers some context and information to members as we all continue to wrestle with the ethical dilemmas with which our current circumstances confront us.

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FEBRUARY 2022 NEWSLETTER