Review Article

Is physician dismissal of vaccine refusers an acceptable practice in Canada? A 2018 overview

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Abstract

Despite robust evidence that routine immunization is effective and safe, some parents refuse some or all vaccines for their children. In 2007, concern that Canadian paediatricians and family physicians might be considering dismissal of vaccine refusers from their practices prompted an ethical, legal, and public health analysis which concluded that dismissal was professionally problematic. We now reassess this important issue in the Canadian context updating ethical, legal, and public health considerations highlighting changes since 2007. In light of the recent strengthening of Ontario's school immunization requirements that include stiffer steps to qualify for a medical, conscience, or religious belief exemption, physicians and health care workers may be under more pressure from vaccine refusers in their practice leading some to contemplate dismissal or even consider no longer offering immunizations at all in their practice. Given the challenges that vaccine refusers may present, we offer an overview for managing vaccine refusal by parents/patients in a medical practice.

Keywords: *Ethics; Health law; Practice dismissal; Public health; Vaccine hesitancy; Vaccine refusal.*

INTRODUCTION

Despite robust evidence that routine immunization is safe and effective in averting a range of vaccine preventable disease-based complications and death, some parents refuse some or all vaccines for their children (1,2). Vaccine hesitancy and/or refusal in Canada has increased during the past decade (1). Guiding the hesitant and refusers is complex and takes time from regular office visits. Some physicians simply dismiss refusers and their families from their practices. In the USA, a 2012 national study determined that 21% of primary care paediatricians and 4% of family practitioners reported 'always/often' dismissing families if they refused vaccines (3). A 2016 US report highlighted that dismissal by paediatricians for vaccine refusal had increased from 6.1% in 2006 to 11.7% by 2013 (4).

In 2007, due to concerns that Canadian paediatricians and family physicians might be considering dismissal of refusers from their practices, some of the authors (NEM, BT) examined the legal, ethical, and public health considerations, and concluded that dismissal was professionally problematic (5). Although dismissal data similar to that collected in the USA is not available in Canada, contemplation of dismissal of patients by physicians remains a serious concern, justifying a revisit of this issue. Given the recent strengthening of Ontario's school immunization requirements that add steps to qualify for a medical, conscience, or religious belief exemption (6), physicians and health care workers may be under more pressure from vaccine refusers in their practice leading some to contemplate dismissal or even consider no longer offering immunizations at all

in their practice. Thus, it is timely to undertake a reassessment of dismissal looking through legal, ethical, and public health lenses. Further, given the challenges that vaccine refusers may present for physicians, we also present an overview for managing vaccine refusal by parents/patients in a medical practice.

ETHICAL ASPECTS

Both parents and physicians have a moral obligation to facilitate the welfare of children, widely considered a vulnerable group; only physicians have these responsibilities systematized in an ethical framework. In the clinical context, important guiding ethical principles include respecting autonomy, beneficence, non-maleficence and justice. Immunization is a public health initiative. For public health, ethical principles of solidarity, transparency, and proportionality have been added, although these are neither well understood nor put into action (7,8).

Physicians advocate for immunization based on its benefit for the individual and for public good, emphasizing that not vaccinating may put others at risk, and may result in concomitant health care cost increases, and perhaps even liability (9). Nonetheless, when patients, weighing whatever factors they consider relevant, refuse to immunize (themselves and/or their children), it may not be ethical for a physician to dismiss them from the practice.

The ethics literature concerning dismissing refusers has grown since 2007, albeit not specific to the Canadian context. Block and Diekema, present a US perspective on dismissal of refusers (9,10), articulating the two most common reasons for dismissal as loss of trust (exhibited as patient's unwillingness to follow professional advice), and potential risk of infection to those in waiting rooms (11). While not specific to vaccine refusers, a British study suggests that the general public views refusal of treatment by parents/caregivers as acceptable despite risks (particularly when grounded on religious reasons) if these are low, but should risks increase beyond a threshold amount, that is, risk of irreparable harm or death, the best interests of the children become paramount (12). While the British study might not see vaccine refusal as warranting dismissal from practice, this general view might shift during an outbreak. It is uncertain though whether British views are consistent with those of Canadians.

While the American Academy of Pediatrics does not apparently condemn dismissal from practice (rather adopting a 'wait and see' attitude) (13), Diekema concludes that dismissal is not an ethical response to hesitancy/refusal because it cannot be said to be in the child's best interests, nor does it benefit the public's health. Indeed, it punishes the child for their caregivers' inflexibility while halting any further opportunity to work with the family about immunization. Thus, it may breach non-maleficence and distributive justice principles; the former neglecting the professional obligation to care for every patient

no matter their beliefs, values, and attitudes (10), and the latter by shifting the clinical burden to those physicians choosing not to dismiss (5,14).

Additionally, it is important to recognize that the doctor-patient relationship is not one of equal power. Physicians have specialist knowledge and are gatekeepers to multiple health services. Physicians can call on the (limited) right of conscientious objection to refuse treatment, for example, of abortion based upon conscience (15). The general rise in such practices, described as 'conscience creep' (16), has obvious significance in terms of social justice, especially in regions with a deficit of family doctors, that is, limiting access to specific procedures and care. The Canadian Medical Association Code of Ethics (2004) acknowledges that physicians may experience tension between different ethical principles, between ethical and legal or regulatory demands, or between their own ethical convictions and the needs of others. However, it goes on to instruct physicians to: *consider first the well-being of the patient; refuse to participate in or support practices that violate basic human rights; recognize and disclose conflicts of interest and resolve them in the best interest of patients; inform patients when personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants* (17). Finally, with respect to ethics, dismissing vaccine refusers is questionable from a consistency perspective. Physicians do not routinely dismiss patients from their practice who refuse to follow clinical advice with respect to smoking, alcohol consumption, healthy eating, etc., so dismissing vaccine refusers represents an inconsistency that probably cannot be defended.

LEGAL ASPECTS

As in ethics, both parents/patients and physicians have legal rights and responsibilities when it comes to treatment decisions respecting children.

By operation of the Charter of Rights and Freedoms (18), all patients can refuse medical treatment, regardless of the harm that might come to them. Parents making health care decisions for their children have a certain margin of appreciation, but they must generally act in the child's best interests, and failure to do so can lead to interventions by authorities (19). Given the proven track record of immunization, and the many salutary public health outcomes of broad immunization uptake, a parent will have a high threshold to meet in making a case that routine vaccination is *not* in his or her child's best interests. There are cases in Canada where vaccinations have been administered against the wishes of a parent. (*Chmiliar v Chmiliar*, at <https://www.canlii.org/en/ab/abqb/doc/2001/2001abqb525/2001abqb525.html?autocompleteStr=chmiliar%20&autocompletePos=1>; *CMG v DWS*, at <https://www.canlii.org/en/on/onsc/doc/2015/2015onsc2201/2015onsc2201.html?autocompleteStr=cmg%20v%20dws&autocompletePos=1>) Indeed, given

the potential dangers of non-vaccination, calls have been made to hold refusers legally liable for harm caused to others by their decision (20).

For their part, physicians owe duties to individual patients and to the broader public, and failures to properly meet these duties can lead to tort and/or professional liability. Very generally, under tort law, physicians can be held liable for the provision of information, advice, or treatment that fails to meet the accepted standard, and that causes foreseeable harm to someone in close enough proximity. For a patient to make an informed choice about immunization, good information must be provided in comprehensible formats; both content and presentation need to be tailored to fit the parent's/patient's needs and capabilities, and it should not be presented in an adversarial manner (21,22).

Physicians also have responsibilities—and can face sanctions for their breach—under their professional regulations and codes of conduct. Most pertinent for present purposes, Article 19 of the Canadian Medical Association's (CMA) Code of Ethics states: *Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.* [CMA (17)]. With respect to dismissal in the vaccine hesitancy/refusal context more specifically, the Canadian Medical Protective Association (CMPA) has summarized the physician's legal responsibilities as (1) obtaining appropriate consent to vaccinate, (2) documenting any refusal, and (3) refraining from dismissing refusers (23). The CMPA emphasises that “*physicians should make every effort to continue to care for patients in the existing doctor-patient relationship in accordance with current standards of care*” (23).

Given this legal and regulatory landscape, there is significant uncertainty about whether physicians can ever dismiss patients/families solely for vaccine refusal. In addition, professional bodies like the national and provincial Colleges of Family Physicians characterise their members as community resources with responsibilities for providing continuing care (i.e., see the four principles of family medicine articulated by the College of Family Physicians of Canada) (24).

Another cautionary aspect is that the dismissing physician may be setting up an access to care problem for the patient and family (5). The shortage of primary care physicians continues across Canada (25,26). Relying on walk-in clinics may not be deemed a sufficient alternative if a dismissed patient/family resists or complains. An alternative to dismissal in extreme conditions, and one that better meets the physician's broader patient and public health responsibilities, is articulated by the CMPA. It advises as follows: *Where a patient (or a patient's legal guardian) has refused immunization, but the vaccine is medically appropriate and necessary to preserve the life or health of the child, it may be necessary for physicians to contact child protection agencies* (23).

Thus, although referral to child protection may effectively end the doctor-patient relationship, in urgent situations such as in measles, diphtheria, or meningococcal outbreaks where the child is unimmunized and at high risk for a vaccine preventable disease and its complications, an application under the child protection scheme to have the child immunized needs to be considered.

PUBLIC HEALTH IMPLICATIONS

The Canadian health context is one of the most complex in the world (26), making it extremely difficult for public health programs to deliver immunization to all the intended recipient populations effectively and uniformly. In some provinces and territories, immunization is predominately delivered in physicians' offices (e.g., Ontario) while in others, it is predominately delivered through public health programs (e.g., Alberta). Even when delivered by public health, this does not mean that the physician has no role to play in encouraging compliance with public health programs.

The public health implications of vaccine refusal are well documented in Canada. Recent measles outbreaks, triggered by transmission from travellers to communities with high immunization refusals in the Fraser Valley, BC in 2014 (27), and in the Lanaudière region of Québec in 2015 (www.phac-aspcgcca/mrwr-rhrr/2015/w13/index-eng.php) were costly for public health in both money and response time needed to interrupt, and contain these outbreaks. These high costs, including morbidity caused by measles, have put growing pressure on stopping such imported outbreaks by global efforts for measles elimination (28). These two outbreaks emphasize that the unimmunized are often clustered and not evenly distributed across a province or territory (1). As physicians dismiss vaccine hesitant patients and families, under-vaccinated children become more clustered in a smaller number of practices and eventually are not able to find a practice that will accept them (29). This can increase the public health workload as this growing pool of refusers would have limited if any opportunity to change their negative vaccine opinions in subsequent discussions with a primary care physician during office visits.

Retaining refusers in one's practice, even if potentially uncomfortable and demanding special precautions in the office (30), provides ongoing opportunities for further discussion and eventual immunization. This is an important strategy from a public health perspective. Research has shown that physician reassurance is a key factor in encouraging vaccine hesitant parents to ultimately accept vaccines for their children (31–33). In contrast, dismissal is unlikely to change an immediate vaccine decision (34), and it decreases opportunities for any gain of trust in the physician, or for vaccine acceptance over time. Importantly, the parent/patient may not refuse all vaccines, suggesting both individual and public health value in retaining them in the practice.

In retaining refusers, it is important to remember that in addition to trust and transparency, respectful discourse is critical to good doctor–patient relationships. A 2010 survey of Ontario parents with children under 16 years of age presenting for naturopathic care reported that a majority (50.5%), albeit a small study, felt pressure from their allopathic physician to vaccinate (35). Of those who discussed vaccination with their physician, 25.9% were less comfortable continuing care as a result, and 5% of respondents were advised by their physician that their children would be refused care if they decided against vaccination. Parents reported excessive pressure to vaccinate, and felt that discussions were not often balanced, injecting a sense of conflict into the relationship. Even highly resistant populations can have a change of mind, but that requires targeted public health messages that build on community values (36). These messages can be reinforced by physicians, but only if the refusers are still in their practice, and the relationship is not undermined by undue pressure or disrespect.

DISMISSAL OF IMMUNIZATION BUT NOT DISMISSAL FROM PRACTICE

While not dismissing vaccine refusers from their practice, some physicians may be considering or have dismissed immunization from their practice. This may entail no longer offer immunization in provinces where family practises are the predominate site of vaccine delivery. At the very least, providers must indicate where parents can have their children immunized and encourage that this be done. Physicians and other health care providers may also refrain from supporting immunization by failing to encourage compliance with immunization programs offered in public health clinics and schools or other sites in provinces and territories where this is the practice for immunization. Similar arguments raised under ethical and legal aspects noted above are also relevant here. Physicians owe ethical and legal duties to individual patients and to the broader public to encourage their patients to comply with immunization programs and, more broadly, to support health promoting interventions for their patients.

MANAGING A VACCINE REFUSING PARENT/PATIENT IN A CLINICAL PRACTICE

Most vaccine refusers are neither especially vocal nor necessarily entrenched in their refusal (2,36). However, the hesitant parent's/patient's social networks—both personal and online—may be vaccine-negative, and will reinforce their hesitancy and/or refusal (37,38). Indeed, studies show that negative vaccination social media can be very influential; 10–15 min on a vaccine-critical website can change one's perception of vaccine safety and

effectiveness, and influence vaccination intentions (39). These parents/patients may perceive not making a decision on immunization as easier than making one, not realising that not accepting vaccines is a decision (omission bias) (40,41).

While vaccine refusers can be frustrating for physicians to counsel during an office visit, having a 'debate' about immunization is not helpful, and may further entrench the parent's/patient's vaccine-negative views. Overly strong or strident messaging can often sound like attacks on beliefs, making it unlikely that the refuser will 'hear' the message (36,42,43). Strategies for helping to preserve and build on the doctor–patient trust relationship and potentially lead the hesitant parent/patient to a vaccine-accepting stance are outlined in the Figure 1 (44,45).

Bearing in mind the above, a productive dialogue might follow this path: (1) Open-ended questioning (e.g., What do you think about vaccines?); (2) Affirmation (e.g., I understand...); (3) Reflection (e.g., You are concerned by/that...); (4) Summarization (e.g., Let me summarize...). This approach has proven to be extremely effective at bringing parties-in-conflict together in the restorative justice setting.

CONCLUSION

In the decade since the 2007 publication on dismissal of vaccine refusers from clinical practice (5), vaccine hesitancy appears to have increased in Canada (1). This 2018 reassessment of the ethical, legal, and public health dismissal considerations provides an even stronger rationale than in 2007 that dismissal is especially professionally problematic in the Canadian context. While still theoretically possible in Canada, dismissal of vaccine refusers should not be adopted lightly by physicians given the 2017 CMPA advice and lack of evidence that dismissal leads to positive outcomes. There are important gaps in our knowledge in this area in Canada, including the prevalence of dismissal from a practice for vaccine refusal, the prevalence of physicians dismissing immunization from their practices and the prevalence of physician non-support for immunization.

In summary, given current evidence, in Canada, family/patient dismissal for vaccine refusal or dismissing immunization from one's practice is neither in the best interests of patients nor the community. One of the most powerful tools for combatting vaccine hesitancy and refusal is a good doctor–patient relationship, the maintenance of which is at the heart of the physician's ethical, legal, and professional responsibilities. Keeping vaccine refusers in one's practice preserves the possibility for future engagements, including a change in mind. In the meantime, learning to agree to disagree in a friendly and honest way avoiding conflict and antagonism, will help build the trust that may lead to more informed decision making and eventual arrival at vaccine acceptance. This is a crucial role for physicians to aid public health in trying to increase vaccine uptake rates in our country over time. The importance of this role cannot be overestimated.

Accept

- Accept and embrace the parent/patient refuser, no matter their decision, make them know they are valued and are being heard; this helps to build trust (Chapter 6 (41)).

Acknowledge

- Find a common ground. Acknowledging that the refuser has good intentions, and affirming that both the parent/patient and the physician want the child/patient to be safe, healthy, and happy, can be very powerful.

Actively Listen

- Never assume or guess why the patient/parent is refusing vaccines. Instead, through dialogue elicit important underlying immunization concerns. Listening to the parent's/patient's responses is key.

Avoid Confrontation

- Confrontational approaches, adversarial stances, and overtly pressurized tactics should be minimized (42). Do not emphasize or repeat myths as this may backfire and reinforce the myth in the vaccine refuser's mind (43). More collegial and motivational interactions can be woven into a routine visit with only a small increase in time (44).

Advise

- Remember that the physician is a (trusted) advisor. Thus, to address the omission bias noted above (i.e., the perception that not making a decision about immunization is not a decision), physicians must ensure that they have advised patients of not only the personal benefits of immunization, but also the public health issues implicated, reviewing the full range of risks and responsibilities (<https://www.caringforkids.cps.ca/handouts/when-parents-choose-not-to-vaccinate-risks-and-responsibilities>).

Annotate

- Document in the chart the refusal (or reasons for hesitancy) and that the risks and responsibilities have been reviewed, an action which addresses the professional-legal requirements set out by the CMPA (21).

Figure 1. Summary of strategies for helping to preserve the doctor–patient relationship, and potentially lead the hesitant parent/patient to a vaccine-accepting stance.

Potential Conflicts of Interest

All authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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