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Shaming Vaccine Refusal

*Ross D. Silverman and
Lindsay F. Wiley*

Vaccines are one of the greatest advances of the twentieth century, but their effectiveness is imperfect and socially contingent. A few infectious diseases, such as smallpox, are susceptible to global eradication. Upon eradication, preventive measures are no longer necessary and health officials cease routine vaccination. For most infectious diseases, however, the goal of vaccination programs is “elimination of infections ... in a defined geographical area[,] [requiring] continued measures to prevent re-establishment of transmission.”¹ For a variety of biological, technological, social, and political reasons, vaccination for measles, pertussis, and other vaccine-preventable infections must be continued as a preventive measure long past the point at which local outbreaks have become rare. This creates a dilemma. To achieve population-wide reductions in premature death and morbidity, vaccination must be widely accepted and implemented. When outbreaks of vaccine-preventable diseases have become rare, however, parents may question whether vaccination is truly in their child’s best interests.²

Vaccination protects the individual, and the state may have a paternalistic interest in protecting children over their parents’ objection, but vaccination of the individual also benefits others. If enough of the population is vaccinated, the resulting community immunity protects everyone by reducing transmission from person to person, making it easier to contain an outbreak.³ Community immunity protects those who are vaccinated but not immune (because the vaccine is ineffective in a small percentage of cases); those who cannot be vaccinated safely because they are too young, are allergic to vaccine components (e.g., eggs), or have immune systems compromised by illness (e.g., leukemia) or medical treatments (e.g., chemotherapy); those who lack access to vaccination for financial or other reasons; and those whose parents have refused vaccination.⁴ If, however, the proportion of a community that is unvaccinated rises above a specific threshold (determined by the transmissibility of the pathogen, the effectiveness of the vaccine, and social characteristics of the community), all who lack individual immunity are at risk.⁵ For measles, for example, up to 5% of a school community may safely remain unvaccinated, enjoying the benefits of others’ accep-

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tance of vaccination.⁶ Who should be allowed to take advantage of this free ride? Certainly those for whom vaccination is medically contraindicated, but what about those who have a religious objection? And what about the (far larger) group of parents who have concerns about vaccine safety, prioritize parental choice over community needs, or have adopted a “natural” lifestyle? The national vaccination rate for measles is high — more than 90% of children are vaccinated,⁷ and the United States has been free of endemic measles since 2000. Travelers continue to contract the disease outside of the US, however, and plummeting vaccination rates in local communities in the US have increased the risk that an imported case will trigger an outbreak. As vaccination has become more accessible over the past two decades, thanks to initiatives like the Vaccines for Children program, Medicaid expansion, and preventive care coverage under the Affordable Care Act, this threat largely arises in communities

and vaccine refusal with negative social traits (selfishness, denial of scientific evidence.)¹⁰

Government persuasion is far less vulnerable to legal challenge than government coercion,¹¹ but some efforts to persuade parents to vaccinate raise ethical concerns. As Dorit Reiss and Lois A. Weithorn have noted, “normative questions about [vaccination] policy options have pragmatic aspects as well” because the success of public health intervention often depends on voluntary cooperation.¹² “Thus, vaccination policies, to be most effective, should resonate with predominant social attitudes and values.”¹³ This paper asks whether vaccination policy should go further, aiming to *shape* the attitudes and values with which it must be harmonized. “[V]accine decision-making [is] a highly social process.”¹⁴ Social norms shape parental choices about vaccination. In turn, parents who signal their choices about vaccination to others shape social norms. Can the design and implementation of laws, policies, and

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where parents choose to forego or delay vaccinations for their children.

Recent measles and pertussis outbreaks have increased many policymakers’ commitment to securing community immunity through a combination of coercion and persuasion.⁸ Lawmakers in several states have tightened the requirements for non-medical exemptions from vaccination requirements tied to school and daycare attendance. California joined Mississippi and West Virginia as the third state to reject all non-medical exemptions. Scholars have suggested imposing tort liability, taxes, and fines on parents who refuse vaccination.⁹ Health officials and nongovernmental organizations have also stepped up education and communication campaigns promoting vaccination. Some campaigns aim to associate vaccination with positive social traits (altruism, good parenting)

programs reinforce the dominant social norm that views vaccines as a routine, low-risk part of medical care for children? Can policymakers promote the norm that parental acceptance of small risks associated with vaccination contributes to the greater good? What about shaming (also known as denormalizing) vaccine refusal,¹⁵ creating or reinforcing social norms against vaccine refusal by characterizing it as a selfish act based on fears unsupported by facts? Can policymakers shape social norms against vaccine refusal by permitting — or even encouraging — private actors such as physicians and employers to discriminate against vaccine-refusing parents? Does it matter if vaccine-refusing parents are more likely to come from privileged socio-economic and racial backgrounds,¹⁶ particularly compared to those who engage in other disfavored health-related behaviors, such as tobacco

use? Is it sufficient to point out that vaccination status is mutable? Or is vaccine refusal so integral to the identity of vaccine-refusing parents that it would be improper for government to expect or persuade them to change? On the one hand, shaming vaccine refusal might be framed as an effort to counter the efforts of anti-vaccination organizations to stigmatize vaccines and parental acceptance of vaccination. On the other hand, anti-vaccination groups are not as wealthy and politically powerful as the tobacco, food and beverage, or infant formula industries. If anything, campaigns to denormalize vaccine refusal might be perceived by many vaccine skeptics as serving the interests of the pharmaceutical industry.¹⁷ How might this unique power dynamic influence the perception of government efforts to persuade parents to vaccinate? Efforts by policymakers and private actors to shame vaccine refusal are unlikely to convince those who are firmly opposed to vaccination (*vaccine-refusing* parents). But shaming vaccine-refusing parents by attaching a negative social meaning to their choice to refuse vaccines might influence *vaccine-hesitant* parents who are on the fence. How might we weigh the potential harms of shaming recalcitrant parents who vehemently refuse vaccination against the potential gains in vaccination among parents who are merely hesitant about vaccines?¹⁸

I. The Impact of Vaccine Promotion Strategies on Social Norms

Policymakers and health officials have sought to influence social norms about a wide range of health-related behaviors and conditions. In some cases, advocates seek to promote positive associations with healthy behaviors, such as using bicycle helmets, serving as a designated driver, getting tested for HIV, and breastfeeding (*normalization*).¹⁹ In other cases, they aim to counter positive associations with harmful behaviors — such as tobacco use, consumption of sugary drinks, and artificial tanning — by associating these behaviors with negative traits (*denormalization*).²⁰ And in still other instances, the goal is to counter negative associations with conditions such as HIV, mental health disorders, and drug addiction (*destigmatization*).²¹ Here, we present four key contexts in which government efforts to promote vaccination may influence social norms: government-sponsored health education and communication campaigns; health education requirements for parents who seek nonmedical exemptions; public disclosure of vaccination rates; and policies that require or adopt a permissive or encouraging stance toward exclusion of unvaccinated children by schools and physicians. These efforts can be understood as government normalization of vac-

ination (e.g., by signaling that most parents choose to vaccinate and associating vaccination with positive traits such as altruism and scientific literacy) or government denormalization of vaccine refusal (e.g., by associating it with negative traits such as exploitive privilege and science denial).

A. Health Education, Communication, and Social Media

Health education and communication campaigns sponsored by government (and similar campaigns sponsored by nongovernmental organizations) raise awareness of the benefits of vaccination and correct misinformation about the risks. Some campaigns go further, drawing on social marketing techniques to promote vaccine acceptance.²² In 2015, for example, the U.S. Centers for Disease Control and Prevention adopted the #TeamVax campaign featuring statements from parents such as “I want my baby to be safe and healthy, that’s why I’m #TeamVax.” The campaign sparked criticism from some, including Megan Heimer, a blogger who advocates for “natural health”:

Yes, if you want your baby to be safe and healthy, you’re on #TeamVax. If you want your child to die from a mild disease they’ll probably never get or you don’t want your kids to suffer brain damage, death, the disease you’re vaccinating against, or some crazy lifelong illness that is far worse than the disease the vaccine is designed to prevent, or you aren’t cool with injecting neurotoxins, hazardous wastes, aborted baby ingredients, and carcinogens into your tiny children, you’re on #TeamStupid ... Who does that? Who thinks it’s even remotely okay to label another parent for a decision that is legally and medically within their realm to make? ... It’s a marketing ploy, designed to pit parent against parent and fuel the fire on vaccine legislation. Whatever the CDC implies ... your vaccinated child won’t die because mine aren’t vaccinated, and there are no teams here. There are just parents making the decision they feel is best for their children and supporting your right to do the same.²³

Heimer’s critique explicitly rejects the notion that parents are on opposing teams while implicitly endorsing the views of vaccine skeptics. She christens this group of skeptics “#TeamStupid,” highlighting the establishment’s rejection of her views, in much the same way that some Trump supporters embraced their status as “deplorables” during the 2016 election. Reappropriation of pejorative labels by vaccine skeptics is hardly a new phenomenon. A 1902 advertisement for the Anti-

Vaccination Society of America invited new members to join “An Association of ‘half-mad,’ ‘misguided’ people, who write, and toil, and dream, of a time to come, when it shall be lawful to retain intact, the pure body Mother Nature gave ...”²⁴

CDC’s #TeamVax campaign stopped short of expressly denigrating parents who refuse vaccination, but private commentators have certainly done so. In 2014, media headlines proclaimed that “Rich, educated and stupid parents are driving the vaccination crisis” (*Los Angeles*

to be extremely well-educated and often have advanced degrees.³¹

Heimer’s and Cáceres’s comments are consistent with cultural cognition phenomena documented by researchers such as Dan Kahan and Elisa Sobo. They describe the process of refusing not as an act of defiance, but rather as one of “becoming,” a way of demonstrating agency, crafting identity, and connecting with a social in-group.³² Through her study of parents at

In 2014, media headlines proclaimed that “Rich, educated and stupid parents are driving the vaccination crisis” (*Los Angeles Times*), “Anti-vaccination debate proves you can’t fix stupid” (*Chicago Tribune*), and “Anti-vaxxers are stupid and contagious” (*Huffington Post*). A 2015 *New Yorker* cartoon by Emily Flake depicted a doctor examining a child, remarking to his worried-looking parents “If you connect the measles, it spells out ‘my parents are idiots.’” Other commentators, including *The Daily Show with Jon Stewart*, *The Onion*, Jimmy Kimmel, and a large group of exasperated physicians in a skit viewed more than 7 million times on YouTube, characterize vaccine-refusing parents as selfish, delusional, misinformed, and privileged

Times), “Anti-vaccination debate proves you can’t fix stupid” (*Chicago Tribune*), and “Anti-vaxxers are stupid and contagious” (*Huffington Post*).²⁵ A 2015 *New Yorker* cartoon by Emily Flake depicted a doctor examining a child, remarking to his worried-looking parents “If you connect the measles, it spells out ‘my parents are idiots.’”²⁶ Other commentators, including *The Daily Show with Jon Stewart*,²⁷ *The Onion*,²⁸ Jimmy Kimmel, and a large group of exasperated physicians in a skit viewed more than 7 million times on YouTube,²⁹ characterize vaccine-refusing parents as selfish, delusional, misinformed, and privileged.³⁰ Mischaracterization of vaccine-refusing parents as “stupid” has prompted backlash from skeptics who readily note that vaccine-refusing parents typically have higher than average formal educational attainment. For example, in a 2016 blog post hosted by the National Vaccine Information Center (a high-profile anti-vaccination advocacy group), Marco Cáceres warned:

If you choose to reject any part of the current vaccine paradigm, as crafted by the government and the pharmaceutical industry, you will be put on to stupid list, even though, ironically, it is widely acknowledged that people who choose to chart their own way on the issue of vaccines tend

a San Diego Waldorf School, where 51% of students had obtained personal belief exemptions, Sobo suggests that “[w]hen it comes to vaccination, solidarity with one’s people networks may be so important that outsider challenges only strengthen beliefs.”³³ As one participant in Sobo’s study explained, vaccine refusal “shows that the parents are individual thinkers ... it takes a lot of work to go against the grain of society.”³⁴ Indeed, one of the reasons some experts prefer the term community immunity is that, among vaccine skeptics, herd immunity is implicitly associated with blindly following the herd without thinking for one’s self.³⁵ While vaccine skeptics like Cáceres typically describe themselves as “choosing to chart their own way on the issue of vaccines,” many parents who refuse some or all vaccinations are choosing to join communities dominated by families with similar beliefs about what constitutes “good,” protective parenting.³⁶ In such communities, infectious disease prevention may be seen as a matter that can be handled by behaviors that signal excellence in mothering, including providing children with outstanding nutrition, exposing them to immunity-boosting practices,³⁷ and close social monitoring to prevent exposure to threatening outsiders.³⁸ Web-based resources and social media may reinforce vaccine skepticism among geographic clusters of like-

minded parents, influencing their perception of risk, expertise, and the integrity of scientific research.³⁹ These findings caution that campaigns to normalize vaccination and denormalize vaccine refusal are likely to be seen by at least some of their target audience as a threat to the identities and communities they have created.

B. Mandatory Health Education for Parents who Seek Exemptions

In addition to general public health education campaigns aimed at increasing and maintaining public confidence in childhood immunizations, a significant vaccination education opportunity occurs with parents at the “point of service,” when infants and children are seen for routine care by primary care providers. Compulsory vaccination laws create an additional opportunity to educate parents about vaccines. In recent years, several states have adopted policies that require parents seeking religious or philosophical exemptions for their children to satisfy educational requirements. Some states require that the parents sign an affidavit declaring they have received health department-approved information packets and understand the risks of exemption described therein. Other states require that exemption-seeking parents go through an “informed refusal” process, meeting with a licensed health care provider to discuss the risks of non-vaccination.⁴⁰ These requirements ensure that parents receive science-based information from a trusted source as part of their vaccine decision making process and increase the administrative burden of pursuing a vaccine exemption.⁴¹ Compared to more lax exemption procedures (in some states a parent need only check a box indicating that they object to vaccination), parental education requirements ensure that vaccination is the path of least resistance and send a stronger signal that vaccination is a social responsibility.

A significant and rising number of physicians with pediatric patients indicate that they are being asked to hold far more substantial conversations about vaccination with a growing proportion of their patients.⁴² Pediatricians report that more than a third of parents who initially refused vaccines change their minds after receiving further education from their pediatricians (with an average period of nearly 4 months elapsing between the initial refusal and acceptance).⁴³ But these conversations take time to conduct thoroughly and sensitively; far more time than is generally allotted for a well-child visit. Some techniques have been found to be more effective than others,⁴⁴ but few if any of these techniques are easily integrated into the high-volume, low-reimbursement⁴⁵ service delivery environment in which such conversations are taking place. This has

resulted in low and inconsistent uptake of best practices for communication by providers and encounters that are stressful and unsatisfying both for physicians and families. As discussed further below, these concerns also have contributed to increased willingness of health care providers and professional medical associations to embrace the dismissal of patients whose parents refuse vaccination.⁴⁶

C. Reporting and Disclosure of Vaccination Status

States have long collected vaccination uptake and exemption information, including through regular reporting by area schools and daycares to state agencies, submissions made by parents and providers as part of the vaccination exemption application process, and through Immunization Information Systems.⁴⁷ As vaccination exemption rates have risen, both media outlets and state agencies have responded in ways that echo the belief embodied in the words of Justice Brandeis — “Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants”⁴⁸ — and have made information about exemption clusters more readily available to the public. The *Chicago Tribune* publishes an interactive online database of the vaccination rates of area public and private schools that can be sorted by such variables as county and vaccination rate (highest to lowest or lowest to highest).⁴⁹ The National Vaccine Advisory Committee, in a 2015 report on vaccine confidence, recommended that schools and childcare facilities make their institutional vaccination and exemption rates publically available.⁵⁰ The California Department of Public Health publishes vaccination rates online on a page titled “How is your school doing?”⁵¹ While such programs do not identify individual exemptors, they do identify schools and communities with high exemption rates, facilitating news reports that shame vaccine refusal.⁵²

Sobo’s study of families in a San Diego Waldorf School community documents higher rates of under- and non-vaccination among families with a longer history of association with the school. She suggests that being part of such a community *cultivates* vaccine refusal and delay. The rate of personal belief exemptions at the school (prior to California’s efforts to phase out PBEs) was over 51% (ten times the rate of private schools statewide), but Sobo suggests “[p]ublicizing that about half of Waldorf students are fully vaccinated and that total non-vaccination is in fact rare” could be an important strategy for “dislodge[ing] vaccination’s social stigma” within a vaccine-refusing subculture.⁵³ “[Unwritten] community rules favoring alternative perspectives and stigmatizing conventional ones” mean that “sources support[ing] talk of vaccine toxic-

ity, ineffectiveness, needlessness (except to those with a profit motive), and developmental inappropriateness for small bodies — [are] more likely to be publicized within the school community via social networks than ... mainstream scientific materials.”⁵⁴ Parents in the community who are on the fence about vaccination could be swayed by information that many parents at the school are quietly vaccinating in spite of the more vocal expressions of anti-vaccination norms.

D. Exclusion of Unvaccinated Children by Schools and Physicians

More than half of states have explicit provisions in their childhood immunization statutes requiring that students with exemptions stay home from school or daycare during a disease outbreak, with many of these states requiring that parents seeking exemptions specifically acknowledge their understanding of this potential exclusion.⁵⁵ Exclusion could functionally “out” an unvaccinated individual, exposing the child or parents to criticism or ridicule.

Some parents have pushed to draw an even brighter line between how schools treat those children who choose to receive exemptions based on philosophical or religious grounds and those who, due to medical conditions, are unable to be vaccinated and are therefore at increased risk due to their lack of personal immunity and the threat of lost herd immunity. One California family living in a school district with high non-medical exemption rates whose child was recovering from leukemia requested that their child’s school “require immunization as a condition of attendance, with the only exception being those who cannot medically be vaccinated.”⁵⁶ Prior to this request, the family had worked with the school district’s nurse to sort the children in their son’s grade, so that, even though more than seven percent of the children in the school had personal belief exemptions (nearly triple the overall state personal belief exemption rate), no other unimmunized children would be placed in his class.

Physicians facing rising numbers of exemption requests by the families of patients in their practices have begun to express concern not only about the challenges associated with holding extended (often un- or under-reimbursed) vaccination counseling discussions with hesitant and exemption-seeking families, but also about the risk unvaccinated children pose to other vulnerable children in their waiting rooms. A study examining 2006 and 2013 national surveys of pediatricians found that by 2013, 1 in 8 physicians reported “always” dismissing patients who persist in refusing recommended vaccines from their practices, a rate twice as high as reported 7 years earlier.⁵⁷ In 2016, the American Academy of Pediatrics came

out strongly in favor of strict state and clinical policies favoring vaccination. In a clinical report titled “Countering Vaccine Hesitancy,” the AAP altered a long-standing policy that had once advised firing vaccine-refusing families from one’s practice as an infrequently used last resort. The 2016 policy states that, while the decision to dismiss a patient “should not be made lightly ... [n]evertheless, the individual pediatrician may consider dismissal of families who refuse vaccination as an acceptable option.”⁵⁸

Exclusion of vaccine-refusing families by pediatricians sends a signal that vaccine refusal is not socially acceptable. It also fuels social media efforts to denormalize refusal. For example, a 2015 Facebook post by Mike Ginsberg, a pediatrician in Fairfield, California has been widely circulated:

In my practice you will vaccinate and you will vaccinate on time. You will not get your own “spaced-out” schedule that increases your child’s risk of illness or adverse event. I will not have measles-shedding children sitting in my waiting room. I will answer all your questions about vaccine and present you with facts, but if you will not vaccinate then you will leave my practice. I will file a CPS report (not that they will do anything) for medical neglect, too.

I have patients who are premature infants with weak lungs and hearts. I have kids with complex congenital heart disease. I have kids who are on chemotherapy for acute lymphoblastic leukemia who cannot get all of their vaccines. In short, I have patients who have true special needs and true health issues who could suffer severe injury or death because of your magical belief that your kid is somehow more special than other children and that what’s good for other children is not good for yours.

This pediatrician is not putting up with it. Never have, never will.⁵⁹

II. Is Shaming Vaccine Refusal Justifiable?

As the articles presented in this symposium issue indicate, the interactions among health, social norms, and government intervention are complex. In the public health sphere, tobacco control and HIV prevention offer seemingly contradictory lessons about the role shame plays in shaping health behaviors.⁶⁰ The lines between normalization of healthy behaviors, denormalization of unhealthy behaviors, and stigmatization of health-related conditions are blurry.⁶¹ For example, a controversial Department of Health and Human Services health communication campaign adopted a primary slogan, “babies were born to be breastfed.”⁶²

that promoted breastfeeding normalization. However, many of the campaign's ads focused predominantly on the risks of *not* breastfeeding. Not breastfeeding (or formula feeding, the unstated alternative) was equated with bull-riding, logrolling, and other high-risk activities at an advanced stage of pregnancy. The ads admonished women: "You wouldn't take risks before your baby's born. Why start after?" provoking significant backlash.⁶³

Public health ethicists and legal scholars have questioned "the propriety of governmental attempts to direct social values and lifestyles" even when these attempts are limited to government-sponsored communications.⁶⁴ For example, some express alarm at government interventions that exploit "unfavorable public sentiment toward smoking ... as an informal social control device that enforces behavioral conformity among smokers."⁶⁵ Is it legitimate for the state to promote acceptance of vaccination (or any other health-related behavior, such as breastfeeding, seatbelt use, and eating a balanced diet) as part of a particular conception of the good life? Even if encouraging vaccination is an important goal, is it reasonable for government initiatives to encourage private parties to socially exclude vaccine refusers, or to discriminate against them by declining to accept their children as patients, or charging them more for health insurance coverage? Extralegal frameworks based on liberal, libertarian, utilitarian, egalitarian, and communitarian notions of justice provide varying answers to these questions. In turn, these answers may inform lawmakers as they consider reform proposals and judges and regulators as they consider questions of constitutional and statutory interpretation raised by vaccination efforts.

Our examination is guided by public health ethics, which Nancy Kass describes as aiming to "advance traditional public health goals [of improving the health of populations rather than of individuals] while maximizing individual liberties and furthering social justice."⁶⁶ Public health ethicists propose, for example, that "data must substantiate that a [public health intervention] will reduce morbidity or mortality; burdens of the program must be identified and minimized; the program must be implemented fairly and must, at times, minimize preexisting social injustices; and fair procedures must be used to determine which burdens are acceptable to a community."⁶⁷ On the issue of minimizing burdens, Kass and many leading public health ethicists argue that public health agents should seek to implement the alternative that is least restrictive in its

infringement upon moral considerations.⁶⁸ Similarly, one of us has joined Lawrence Gostin in advocating for "a systematic evaluation of public health regulation that draws on public health science and ethics to assess (1) regulatory justifications, (2) risks to health and safety, (3) the effectiveness of interventions, (4) economic costs, (5) personal burdens, (6) distribution of benefits and burdens, and (7) the transparency and legitimacy of the regulatory process."⁶⁹ As discussed above, the risks associated with vaccine-preventable illness and the justifications for securing community

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immunity as a public good are well documented. We assume that the regulatory process by which efforts to normalize vaccination and denormalize vaccine refusal should be transparent and participatory and that the economic costs of the interventions discussed in Part I are minimal. Therefore, in this Part, we focus on four basic considerations to guide our assessment of government efforts to shape social norms about vaccination: effectiveness, burdens on individual liberty and dignity, and the distribution of burdens and benefits.

A. Effectiveness

Although "significant gaps exist in measuring, monitoring, and tracking vaccine confidence," evidence suggests that norms shaped by social networks, the media, education and communications from health care providers "play[] a central role in instilling, maintaining, and fostering vaccine confidence."⁷⁰ Tightening exemption requirements and publically available vaccination rates signal that vaccination is consistent with prevailing social norms and contribute to increased vaccination rates, but these approaches do little to address the underlying concerns, beliefs, and values of vaccine-hesitant parents.⁷¹

While acknowledging gaps in the evidence, the National Vaccine Advisory Committee has recommended that vaccination programs and providers "actively reinforce" and promote public awareness

that on-time vaccination is the social norm.⁷² While the NVAC does not define the phrase “actively reinforce,” it should be noted that such efforts do not necessarily include active denigration of parents who do not adhere to such a norm. Denormalization efforts have been credited with enhancing smoking reduction initiatives; however, it is unclear whether such efforts have been (or will be) effective in maintaining vaccine confidence, acceptance, or increasing vaccination coverage, or in fostering or maintaining trust in government recommendations. More research is needed to assess the effectiveness of efforts to promote the social acceptability of vaccination as a component of good parenting, the influence of publically disclosed vaccination rates on parental choices, and parental responses to the exclusion of unvaccinated children from schools and physician practices, among other questions.

B. Respect for Individual Liberty

Courts have generally deemed constitutional guarantees of privacy, autonomy, and religious freedom insufficient to invalidate compulsory vaccination laws even in the absence of a religious exemption.⁷³ Nevertheless, the argument that vaccination programs infringe on parental choice is ethically and politically salient. Most public health ethics frameworks adopt some form of the principle that interventions should adopt the least restrictive alternative for achieving a public health goal. As a legal matter, government is only required to adopt the least restrictive alternative in cases where the courts apply strict scrutiny because a fundamental right or suspect classification is implicated. But ethical constraints can and do require more than mere legality.

Is shame liberty-restricting? Is it coercive? The intervention ladder developed by the Nuffield Council on Bioethics ranks public health interventions from least to most intrusive, with stronger moral justifications required for more intrusive interventions: 1) Do nothing or simply monitor the situation; 2) Provide information; 3) Enable choice; 4) Guide choices through changing the default policy; 5) Guide choices through incentives; 6) Guide choice through disincentives; 7) Restrict choice; and 8) Eliminate choice.⁷⁴ Childhood vaccination policy is multi-faceted, with components falling on multiple rungs of the ladder (e.g., health education falling on the minimally restrictive “provide information” rung; limiting exemptions falling on the much higher “restrict choice” rung). Although discussions of incentives and disincentives that guide

choice typically focus on economic costs and benefits (e.g., excise taxes or subsidies) and access to benefits (e.g., doubling the value of supplemental nutrition assistance benefits when they are used to purchase fruits and vegetables), social acceptance and exclusion may work in similar ways. Social approval can be understood as an incentive that guides choice (rung 5), while shame acts as a disincentive (rung 6). Civil libertarian critics, most famously Robert Crawford⁷⁵ and Petr Skrabanek,⁷⁶ have used the term *healthism*

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to decry government interventions that “go[] beyond education and information on matters of health and use[] propaganda and various forms of coercion to establish norms of a ‘healthy lifestyle’ for all.”⁷⁷ Author Nir Eyal notes that, “understood broadly to include embarrassment, stigma effects, and any compunction in general,” shame “can affect our choices a lot while objectively limiting our freedom of choice only little.”⁷⁸ Eyal describes public health law interventions as diverse as smoke-free laws, directly observed therapy for tuberculosis, and New York City’s attempt to prohibit the sale of sugary drinks in containers larger than 16 ounces as “creat[ing] slight stigma, which may be objectively a trifle but which we dread.”⁷⁹ Applying economic analysis to tobacco denormalization efforts, Gary Lucas has used the term “psychic tax” to describe the nonfinancial disincentive associated with graphic warning labels depicting gruesome and socially undesirable effects of smoking. Lucas also points out that even if public health advocates support government manipulation of social norms about tobacco use (and by analogy vaccination, though Lucas does not discuss it) they should nonetheless be concerned about a “slippery slope, leading to the adoption of laws that many people will find objectionable or even abusive.”⁸⁰ He points to state laws mandating misleading statements by doctors about purported risks of abortion: “Abortion-rights advocates will likely find it easier to oppose this practice if the public generally views psy-

chic taxes with suspicion than if psychic taxes are an established instrument for manipulating behavior.”⁸¹ Lucas’ point, perhaps unintentionally, turns the central insight of the denormalization strategy against its proponents: take care lest government denormalization become normalized.

C. *Respect for Individual Dignity*

Is government intervention (or a permissive governmental stance toward the efforts of private parties) to shame vaccine-refusing parents oppressive? The principle of dignity and respect for “the realization of one’s distinctive identity as a unique human being”⁸² may be useful for analyzing some of the negative impacts of shaming that are not fully captured by the notion of liberty. Antidiscrimination law suggests that the key question is whether vaccine refusal is “so fundamental to personhood that ‘it would be abhorrent for government to penalize a person for refusing to change ...’”⁸³ In developing their own anti-healthism principle (one with a more egalitarian bent than Crawford’s and Skrabanek’s), Jessica Roberts and Elizabeth Weeks Leonard assert that “individuals should not be disadvantaged on the basis of traits that they did not choose, did not cause, and cannot change” but, on the other hand, “the law can appropriately incentivize individuals to alter their ‘bad’ conduct or choices and gain the privileges enjoyed by others who make ‘good’ choices.”⁸⁴ Were mutability the only consideration, shaming vaccine refusal would be justifiable. Unlike, say, breastfeeding, which must be initiated soon after birth, accepting vaccination continues to be a viable option for parents who have previously refused. But mutability is not the only basis for distinguishing beneficial discrimination from oppressive discrimination. Roberts and Leonard note that “antidiscrimination law has moved beyond immutability” with respect to characteristics like religion and sexual orientation on the grounds “such characteristics are very difficult, as a practical matter, to change, or ... are so fundamental to personhood that ‘it would be abhorrent for government to penalize a person for refusing to change them.’”⁸⁵ Vaccine refusal is neither immutable nor difficult to change. Thus, the remaining question is whether it is fundamental to the personhood, the identity, of vaccine-refusing parents.

Put another way, the key question is whether directing shaming actions toward vaccine-refusing parents amounts to *true* stigma. Stigmatization is the social marginalization and/or expulsion of a population based on society’s characterization of certain traits or behaviors as deviant.⁸⁶ Stigmatization is critiqued as unethical, due to the act’s propensity for dehumanizing and “othering” its targets.⁸⁷ Ethicists and legal

scholars — including Scott Burris, Jennifer Stuber, and Ronald Bayer — have built on the general principles of public health ethics and sociological analyses of stigma and health, to assess whether tobacco denormalization is consistent with the destigmatization strategy adopted by many public health advocates with respect to HIV prevention.⁸⁸ Elsewhere, one of us has articulated several factors to guide the assessment of public health shaming: Shame-based public health intervention amounts to stigma where there is (1) a power differential between the stigmatized and the “normal” that makes possible; (2) labeling, stereotyping, and categorization of the stigmatized as separate from the normal; and (3) the experience of status loss and discrimination by the stigmatized group that is enduring and engulfs the entire identity. Finally, after the first three factors have been considered, a balancing of the negative impact of the purported stigmatization against the potential utility of shame-based sanctions (in terms of public health costs and benefits) may be appropriate.⁸⁹ As Burris notes with respect to tobacco denormalization:

One could argue that smokers are not really relegated to a “them” status, that smoking does not supplant all other traits and is not automatically or durably associated with a range of negative stereotypes. Or one could argue that it satisfies all the criteria of stigma in a formal way, but that in none of the domains is the effect serious enough to rise to the level of stigma.⁹⁰

Similarly, Bayer has argued that tobacco denormalization involves “marginalization that can be shed,” that “permits, even as its goal, the reintegration of those who have been shamed”⁹¹ (although the denormalization of smoking may have a disproportionate adverse impact on some already vulnerable, socially stigmatized populations, such as people with severe mental illness, whose rates of smoking are much higher than in the general population).⁹² By analogy, refusal of vaccines is not so all-encompassing and shaming vaccine refusal is not so identity spoiling as to be inescapable. Even for parents who refuse to be “reintegrated” into the mainstream by bowing to social pressure to vaccinate, the situations in which their vaccine refusal is known to others, subjecting them to humiliation, are limited.

D. *Fair Distribution of Burdens and Benefits*

Elsewhere we have expressly advocated for a *health justice* approach to assessing public health intervention.⁹³ Most relevant for the purposes of this paper, the health justice model emphasizes the need for more

probing inquiry into the effects of class, racial, and other forms of social and cultural bias on the design and implementation of public health intervention.⁹⁴ It also counsels prioritization of facilitating social-ecological interventions (e.g., ensuring sufficient access to health care and public health services and other forms of social support) over individually-targeted, victim-blaming behavioral interventions (e.g., punishments and rewards that put the onus on individuals to make healthier choices without necessarily making it easier for them to do so).⁹⁵

As noted above, parents who choose to decline or delay vaccinations — as opposed to those whose children are undervaccinated because they lack adequate access to affordable care — tend to be from higher socioeconomic backgrounds and have higher formal educational attainment. There could be spillover effects, whereby parents and children who lack access to vaccination are stigmatized by efforts aimed at parents who choose not to vaccinate. It may be the case that (typically privileged) policymakers and public health officials are blind to the influence of economic and other social factors on access to vaccination and thus may overestimate the extent to which under- and non-vaccination are attributable to unfettered parental choices. Barring that, shaming the choices of relatively privileged families raises few distributive justice concerns.

III. Concluding Reflections

The absence of regular, severe infectious disease outbreaks increases the need for effective communication campaigns that convey the continued need to maintain and strengthen our communal protection against highly communicable but preventable illnesses. Our increased understanding of how and where vulnerabilities in community immunity arise, coupled with our capacity to collect and share information with the public, allows us to better identify and monitor the public's health and respond when threats arise. Vaccination is the norm for the vast majority of the American public. Supporting this norm by ensuring universal access to vaccination and information about vaccines, promoting positive public health messages that normalize vaccination, and the enforcement of rules that preference adherence to this norm over the decision to forego vaccination is ethically, legally, and politically acceptable. The strategies described above — government-sponsored social marketing campaigns such as #TeamVax, public disclosure of vaccination rates by school or county, exclusion of unvaccinated children from schools during an outbreak and a permissive stance toward physicians' dismissal or refusal of unvaccinated patients — do not yet cross the line

into the harsh social shaming that some private commentators have adopted. Even if government efforts start shifting toward imposing or reinforcing social disincentives to influence parental decisions about vaccination in the future, shaming vaccine refusal would still be less restrictive than compulsory vaccination laws and probably would not amount to true stigmatization of the type that is flatly unethical. Unlike mental health, addiction, or formula feeding, vaccine refusal is eminently mutable. Unlike sexual orientation or religion, vaccine refusal is not so integral to an individual's identity that it would be wrong for government to expect the individual to change. Unlike skin color or weight, vaccine refusal is not so visible to others that it exposes an individual to inescapable, all-encompassing, discrediting stigma.

Nonetheless, public health advocates should be vigilant. Tactics that leverage social capital and connections, shame, and sharpen rhetoric addressed toward vaccine-refusing parents could alienate vaccine-hesitant parents in ways that are counterproductive. Much of the discussion about public health's use of denormalization strategies has centered on low-cost, high-impact efforts to counteract the influence of well-funded, politically powerful corporate interests and cynical (but highly effective) marketing campaigns by "Big Tobacco," "Big Soda," and the like. Commercial interests do engage in efforts to denormalize vaccination. Some antivaccination websites are connected to commercial enterprises selling alternative remedies. For example, Mike Adams's Health Ranger Store (which sells everything from cow colostrum to a \$3500 platform that "improves blood flow" when you stand on it) is attached to Adams's antivaccination website, NaturalNews.com. Dr. Joseph Mercola's Mercola.com offers a similar combination of antivaccination commentary and expensive natural health products. But these companies are not in the same league as Pepsi or R.J. Reynolds. Efforts to shame vaccine refusal, unlike efforts to combat advertising that associates soda consumption with youthful energy or smoking with sexiness, directly confront the identity and beliefs of individuals. Because issues that touch upon one's personal identity are typically more difficult to unseat, public health advocates may be tempted to turn the heat up higher on outliers. We are concerned that the more personal these tactics become, the closer public health advocates get to degrading the public's fragile trust in government efforts to protect health and safety.

Note

The authors have no conflicts to declare.

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