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Can mandatory vaccination be ethically justified? A deontological perspective.

Mary Lowth

Abstract

Covid-19 is the one of the greatest health challenges the world has faced in recent times, and mass vaccination appears to offer the least harmful 'way out'.[1] At individual level vaccination reduces vulnerability to disease, but at population level vaccination suppresses disease circulation, so that those whom vaccination cannot protect are protected by the rest.[2] The level of vaccination needed to prevent disease circulation varies with disease transmissibility and vaccine efficacy. For Covid-19, with current vaccines, it has been estimated as approaching one hundred per cent.[3] In these circumstances, do we each have a moral duty to agree be vaccinated? If so, is it ethically permissible to coerce this decision through mandation?

The case for mandating vaccination against Covid-19 has largely been made on broadly consequentialist principles, suggesting that vaccination is morally demanded by principles of fairness and the maximisation of utility, and that mandation is therefore justified. This analysis has some flaws from the deontological perspective; its understanding of what is easy (and fair) takes no account of differing individual perspectives. As a result vaccine hesitancy is treated as of no significance, and the case for preserving any autonomy at all, should enforced vaccination prove the most effective measure for the public good, is unclear. This

[1] Hansard HC 19/4/21 vol 692 c655 Matt Hancock, Secretary of State of Health.
[2] Nuffield Council on Bioethics, Vaccine access and uptake (NCOB Policy Briefing, 2021) 2.
[3] Kamran Kadkhoda, 'Herd Immunity to COVID-19' (2021) 155 Am J Clin Pathol 471.

paper relies instead on a broadly deontological analysis to suggest that, in the current context of the pandemic, the duty of rescue extends to choices we would otherwise much prefer not to make, supporting a moral obligation to choose vaccination even when we would much prefer not to. It suggests, however, that only selfish choice can be coerced, and the permissible limit of coercion will in practice be determined by medical ethics since - irrespective of what the law says - medical personnel will only vaccinate persons whose agreement is sufficiently voluntary as to constitute consent.

Introduction

The current debate about mandatory vaccination for Covid-19 does not consider compulsory vaccination, but the use of incentives and/or disincentives to influence each person's vaccination decision.[4] Its purpose would be to ensure that people who would refuse vaccination but for such influence, instead agree to it. Influences may range from privileging the vaccinated to removing normal privileges of community membership from the refusers. The ethical tension beneath this is between individual freedom and duty to the common good. Two central questions must be answered; is there a moral duty to choose to be vaccinated and, if so, how far (if at all) is it permissible to coerce that decision?

A review of published ethical arguments for mandatory vaccination against Covid-19 reveals a relatively consistent approach that relies on a consequentialist analysis, focussing principally on the maximisation of public good, and the principle of fairness.[5] The World Health Organisation (WHO) also suggest a broadly consequentialist approach, that ethical analysis should consider:[6]

[4] World Health Organisation Health Ethics & Governance, COVID-19 and mandatory vaccination: Ethical considerations and caveats (13/4/2021, 2021).
[5] Summarised in Alberto Giubilini, 'Vaccination ethics' (2021) 137 British Medical Bulletin 4.
[6] World Health Organisation n4, 1-2.

Proportionality of impact on freedom compared to purpose.

Necessity: could necessary vaccination levels be reached without mandation.

Effectiveness: will mandating increase vaccination levels.

Vaccine safety and efficacy

Acceptability and availability of delivery

The effect of mandation on public trust.

Savulescu, in several articles arguing for mandatory vaccination, suggests that it is clearly justified where there is a grave threat to public health, and that it will be effective provided that the level of coercion is proportionate.[7] This relies on a consequentialist interpretation of decision theory (in which the measure of effectiveness is whether it maximises vaccination uptake, bearing in mind that coercion can be counterproductive), and suggests that the judgement of vaccine risk is the objective opinion of policy-makers.[8] The argument states that the impact on freedom must be proportional, but does not explain how this is to be determined, and assumed all individuals will be coerced to the same degree.

The consequentialist approach ignores differences between individual attitudes to the virus which may make choosing to be vaccinated harder for some than others. This approach is potentially illiberal as it risks disproportionately impacting the freedom of minorities who differ from the norm. It is unsurprising that a consequentialist analysis examines the question only from the community perspective; consequentialists criticise deontologists for overly prioritising individual interests against those of the community, and deontologists criticise consequentialists for doing exactly the opposite.[9] If, therefore, mandatory vaccination can also be justified from a deontological perspective, this might look more convincing.

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[7] a. Julian Savulescu, 'Good reasons to vaccinate: mandatory or payment for risk?' (2021) 47 Journal of Medical Ethics 78.

b. Julian Savulescu, Alberto Giubilini and Margie Danchin, 'Global Ethical Considerations Regarding Mandatory Vaccination in Children' (2021) 231 J Pediatrics 10.

[8] Savulescu, n7a, 78-9.

[9] Allen E Buchanan, 'Assessing the Communitarian Critique of Liberalism' (1989) 99 Ethics 852.

The first section considers whether autonomously choosing Covid-19 vaccination is a moral requirement, basing the analysis on each person's duty of rescue. The second section asks whether, if choosing vaccination is morally required, coercion is ethically justified and, if so, how we should determine what level of coercion is ethically permissible.

I: Is choosing vaccination against Covid-19 morally required?

A. The duty of rescue

> No man is an Iland, intire of itselfe; every man
> is a peece of the Continent, a part of the maine [10]

Giubilini, Douglas and Savulescu argue that choosing vaccination is a moral duty to the collective good, on the consequentialist Principle of Group Beneficence,[11] which is the principle that the obligation to act for the others' benefit is morally normative.[12] They also suggest that Kant's universalisability test[13] supports vaccination as the moral choice if its consequences are beneficial.[14] This somewhat misconstrues Kant's maxim, which says that the rightness of a given act depends first upon the consequences of that singular act, and only then should one consider whether therefore, the duty applies to all in a moral society.[15] To

[10] John Donne, *Meditation XVII, Devotion on Emergent Occasion* (1624).
[11] e.g., Alberto Giubilini, Thomas Douglas T and Julian Savulescu, 'The moral obligation to be vaccinated: utilitarianism, contractualism, and collective easy rescue' (2018) 21 Medicine, health care, and philosophy 547, 550.
[12] This is a foundational principle in ethics e.g., Hume saw benevolence to others as a fundamental (and the most important) human moral characteristic, Mill saw beneficence as the only supreme or preeminent principle of ethics, and Kant sees beneficence as a universal duty.
[13] Immanuel Kant, Groundwork of the Metaphysics of Morals (1785) 4:421); 'Act only in accordance with that maxim through which you can at the same time will that it become a universal law.'
[14] Giubilini, Douglas and Savulescu n11, 552.
[15] The principle makes clear that each act must be judged on the merits of the individual duty it fulfils, and only then should the moral agent consider whether it is possible for everyone, in a moral society, to have the same duty.

draw ethical justification only from the consequences of everyone acting in a certain way is itself consequentialist.[16] The deontological analysis therefore begins with asking why, from the individual perspective, we might have such a duty.

As Donne says above, we are not alone. We are a social species - community consists of collaborating persons. Geertz suggests that we cannot be human without this characteristic since it has determined how both our bodies and our morality have evolved.[17] Autonomy supports individual survival and flourishing independent to the group, but without community it would not get us far, nor would the community get far without its commitment to each of us. This mutual reliance generates duties owed in both directions, although these are not necessarily matching or reciprocal (e.g., the community's duties to a child differ from a child's duties to the community). Harari sees such duties as the root of all societal cooperation, including the conceptualisation of morality.[18] Singer sees them as a 'consciously chosen ethic with an expanding circle of moral concern.'[19] This duty to community is the basis of the moral duty of rescue, from which the duty to choose vaccination might arise. However, to determine whether it does arise, the force of the duty needs to be determined.

The existence of a duty of *easy* rescue (where the cost to the rescuer is very low and the gain to the rescued is very high) is accepted by both consequentialists and deontologists. Bentham saw a 'duty of every man to save another from mischief, when it can be done without prejudicing himself.'[20] Kant saw it as an imperfect duty,[21] that is, one which does not always hold true but can be flexible according to context. Ross saw the obligation to rescue as extending to all in the world whose lot we might improve.[22] Singer made a well-known argument for the duty of easy rescue as a duty of all moral agents to prevent serious harm at

[16] Shelly Kagan, 'Do I Make a Difference?' (2011) 39 Philosophy & Public Affairs 105.
[17] Clifford Geertz, *The interpretation of cultures: selected essays* (Basic Books 1973) 73-4.
[18] Yuval Noah Harari, *Sapiens: a brief history of humankind* (2018) 20-28.
[19] Peter Singer, *The expanding circle: ethics and sociobiology* (Princeton University Press 2011).
[20] Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (1780) (Oxford 1907) 292.
[21] Immanuel Kant, *The Metaphysics of Morals* (1797) 6:390-394.
[22] William D Ross, *The right and the good* (Clarendon Press 1930) 21.

easy cost to themselves.[23]

> If I am walking past a shallow pond and see a child drowning in it, I ought to wade in and pull the child out. This will mean getting my clothes muddy, but this is insignificant, while the death of the child would presumably be a very bad thing.[24]

The limit of the duty of easy rescue is less clear. Scanlon suggests that it obliges us to *slight or even moderate sacrifice* to prevent significant harm to others.[25] Beauchamp and Childress suggest that only *very significant* risks or burdens absolve us of this moral duty.[26] Menzel suggests that the duty does not require unrealistic effort.[27] Rulli and Millum suggests that there is broad societal consensus for such a duty where the cost to the rescuer is minimal, but this does not extend to a difficult rescue such as an obligation to fulfil an overwhelming number of low-cost rescues;[28] if a person is drowning and we can swim we may have an obligation to rescue, but if a thousand persons are drowning we are justified in ceasing our efforts before we are so exhausted that we drown too.

B. Is vaccination an easy rescue?

The consequentialist analysis suggests that Covid-19 vaccination is a duty of easy rescue on the basis that

> when the cost to an individual is small of some act, but the benefit or harm to another is large, then there is a moral obligation to perform that act.[29]

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[23] Peter Singer, 'Famine, affluence and morality' (1972) 1 Philos Public Aff 229.
[24] ibid, 231.
[25] Thomas Scanlon, *What we owe to each other* (Belknap Press 2000), 224.
[26] Tom L Beauchamp and James F Childress, *Principles of biomedical ethics* (OUP 2009) 202.
[27] Paul Menzel, 'The Moral Duty to Contribute and its Implications for Organ Procurement' (1992) 24 Transplantation Proceedings 2175.
[28] Tina Rulli and Joseph J Millum, 'Rescuing the duty to rescue' (2016) 42 J Med Ethics 260, 216.
[29] Savulescu, n7a, 82.

Savulescu sees this duty of rescue as easy because the vaccine is safe and effective, and objective test.[30] Giubilini, too, suggests that the safety of the vaccine should be subject only to objective judgement because

> if subjective costs were factored in, then basically anything could be considered over-demanding at least for someone, with the undesirable consequence that one's personal moral or religious views could exempt anyone from any moral obligation.[31]

However, whilst the vaccine is seen as *sufficiently* safe from the perspective of the policymakers, the 'easiness' of rescue is surely to be determined by the one who must carry out the duty, since they must first choose to act.

The vaccine is certainly *relatively* safe compared to Covid-19 itself, but it is not risk free. In May 2021 current Covid-19 vaccines appeared to carry a 1-5 per million risk of life-altering thrombosis,[32] and the UK government has already announced a vaccine damage payment scheme.[33] For any healthy adult vaccination remains safer than remaining unvaccinated - but this is partly because Covid is still in circulation. At circulating infection levels in London on May 9th 2021, for a healthy white adult aged 25, the chance of dying after receiving the vaccine was 1-5 in a million, whilst the chance of contracting then dying of Covid was 1 in 330,000.[34] These, however, are absolute risks. Risk perception vary enormously between individuals,[35] and it is risk perception which defines the difficulty, for an individual, of choosing vaccination. The human perspective on the tiny chance that a very unlikely positive event will

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[30] Savulescu, n7a, 80.

[31] Alberto Giubilini, 'An Argument for Compulsory Vaccination: The Taxation Analogy' (2020) 37 Journal of Applied Philosophy 446, 452.

[32] Ingrid Torjesen, 'Covid-19: Risk of cerebral blood clots from disease is 10 times that from vaccination, study finds' (2021) 373 BMJ n1005.

[33] UK government, 'Vaccine damage payment' <https://www.gov.uk/vaccine-damage-payment> accessed 15/6/21.

[34] University of Oxford qCovid risk assessment: https://www.qcovid.org/Calculation.

[35] Nuffield Council on Bioethics, Vaccine access and uptake (NCOB Policy Briefing, 2021) 2.

be realised drives the purchase of millions of lottery tickets every week, and unlikely events happen all around us, every day.

The reasons for vaccine hesitancy[36] were summarised by the World Health Organisation in 2014 as falling in three interrelated areas;[37]

> **Confidence**: trust in the effectiveness and safety of vaccines, the system that delivers them, and the motivation of policymakers.
>
> **Vaccine complacency** perceived risks of disease are seen as relatively low
>
> **Vaccine convenience** accessibility of the vaccine, and acceptability of the service provision.

UK vaccine hesitancy is being monitored by the Office for National Statistics (ONS). At the end of May 2021 6% of adults reported vaccine hesitancy, and only 2% said they were very or fairly unlikely to accept the vaccine.[38] Concerns regarding side-effects and vaccine efficacy were the top reasons given for negative sentiment.

For those who are afraid of vaccination[39] the relatively undisputed duty of easy rescue may therefore not apply. Consequentialist justification ignores this view. Pieruk argues that the existence of vaccination as a beneficial community tool obliges all to contributing to group benefit and take a fair share of risk.[40] Giubilini suggests that vaccination is morally obligatory

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[36] Vaccine-hesitant individuals are defined as 'a heterogeneous group that are indecisive in varying degrees about specific vaccines or vaccination in general. Vaccine-hesitant individuals may accept all vaccines but remain concerned about vaccines, some may refuse or delay some vaccines, but accept others, and some individuals may refuse all vaccines.'

[37] World Health Organisation, Report of the SAGE working group on vaccine hesitancy, 2014) 12-13.

[38] Office for National Statistics, 'Coronavirus and vaccine hesitancy' (ONS, 2021) <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandvaccinehesitancygreatbritain> accessed 15/6/21.

[39] This is true irrespective of whether they predominantly trust information which is incorrect, or mistrust information which is correct. indeed, Tansey and Archard note that attempting to suppress incorrect information may itself worsen mistrust; David Archard and Sue Tansey, 'Getting the jab done' (Nuffield Council on Bioethics, 2020) <https://www.nuffieldbioethics.org/blog/getting-the-jab-done> accessed 4/3/21.

[40] Roland Pierik, 'Mandatory Vaccination: An Unqualified Defence' (2018) 35 Journal of Applied Philosophy 381, 388.

because it represents a fair distribution of the burdens of a transmissible disease.[41] However, the burdens are not distributed equally or fairly if we acknowledge that, for those who mistrust the vaccine, the duty of rescue is much more difficult. Navin suggests that mandated vaccination could only be *fair* if the cost (or easiness) were roughly the same for everyone.[42]

From a deontological perspective the duty of easy rescue applies to each of us, up to a certain level of difficulty. It is less clear how we determine how difficult a rescue this requires. For vaccination to be morally required for the vaccine hesitant, a duty of more difficult rescue would need to be established.

C. Is there a duty of difficult rescue?

Scanlon suggests that the duty of rescue obliges us to make 'a slight or even moderate sacrifice' to prevent significant harm to others.[43] Bioethicists have traditionally drawn the upper boundary of the duty of rescue at the level of interventions which 'would not present very significant risks, costs, or burdens' to the rescuer.'[44] Rulli and Millum point out that the limits of the duty of rescue are not agreed, although they suggest that we do tend to agree that it is greater both where we are connected to those to whom we owe the duty, and where the danger from which rescue is required is severe.[45]

One possible guide to where the limits of the duty lie for a given community could be found in the duties that the community has already accepted as socially normative. Savulescu, for example, relies on this as he suggests that mandating vaccination is justified in a community which already accepted significant infringements of freedoms in grave emergencies

[41] Alberto Giubilini, 'Fairness, Compulsory Vaccination, and Conscientious Objection' in Giubilini A (ed), *The Ethics of Vaccination* (Springer International Publishing 2019) 95.
[42] Mark Navin, *Values and vaccine refusal. Hard questions in ethics, epistemology, and health care* (Taylor & Francis Ltd 2015) 142.
[43] Scanlon n25, 224.
[44] Beauchamp and Childress n26, 202.
[45] Rulli and Millum n28, 261.

comparable to the pandemic.[46] His comparators are wartime conscription, taxation, compulsory wearing of seatbelt and mandatory vaccination policies elsewhere.[47]

It is possible to fault these examples as insufficiently relevant to Covid-19; the war was generations ago and society and its values may have changed. Taxation been evolved gradually with consensus through decisions made by democratically elected governments rather than imposed unilaterally. Seatbelts proportionately benefit the wearer. The level of coercion this population will accept in the common good may differ from other populations, whose political philosophies may differ from ours. Nevertheless, the examples suggest that community acceptance of a mandated duty of rescue may indicate where the community feels its limits lie, assuming this is an 'en masse' community decision rather than a slim majority. Kant suggests that the united will of the people, 'insofar as each decides the same thing for all and all for each' justifies legislation.[48] During both World Wars an extreme duty of rescue (conscription and the risk of loss of life) was accepted by the vast majority of people in response to existential threat. In World War Two, for example, there were never more than 1.8% of men registering as conscientious objectors in any age group, and these numbers declined after 1940 as the perceived threat (of invasion) increased.[49] One could argue that the level of the duty of difficult rescue recognised by a population overwhelmingly, or *en masse*, offers a guide to the limits of the duty of rescue for that population.

Faced with Covid-19 today's UK population has accepted extreme sacrifices of normal freedoms, such as foregoing the right to be with dying loved ones, to hold weddings and funerals and to access normal education. These are freedoms that, unarguably, we would much prefer to have retained. There has been some dissent, but little actual resistance, suggesting an *en masse* acceptance of a duty of difficult rescue that extends to things we would

[46] Savulescu, n7a, 81.
[47] Savulescu, n7a, 81.
[48] Kant, n21, 6.313-4.
[49] Allyson Breech, 'Conscientious Objectors During Britain's Last Popular War' (Fellows Thesis, Texas A&M University Department of History 1999) 10.

normally much prefer not to choose. This suggests that the duty of rescue, in this community and at this time, extends to the level of much preferring not to be vaccinated, leaving as 'conscientious objectors' those for whom vaccination would be more difficult than this. This position might change in the face of clear evidence of 'en masse' commitment to a duty of extremely difficult rescue, such as might occur if Covid-19 becomes more transmissible and more lethal. It also might reduce if the risks of Covid-19 are widely perceived to decline.

The duty of rescue, in the context of Covid-19, rests on each of us. What this means is that we are each obliged to weigh this duty (to accept vaccination even if we would much prefer not to) against our own autonomous preferences when making our vaccination choice.

D. The duty of rescue and marginalised groups

The question of *who* finds vaccination the most difficult is significant,[50] since vaccine hesitancy appears greater in groups who are traditionally considered marginalised relative to policymakers. The ONS 6% hesitancy figure above disguises variation in these groups: 13% in young adults, 21% in Black or Black British adults, and 10% in adults in the most deprived areas of England (as opposed to 3% of adults in the least deprived areas).[51] Mistrust in the vaccine may relate both to risk perception concerning the vaccine and to mistrust of the messenger.

One of the central themes in the debate regarding the ethics of mandating vaccination has been the *unreasonable nature* of the views of those who do not trust vaccination. Pieruk, for example, attributes vaccine denialism to beliefs which are irrational in the face of objective evidence. He suggests their presumed source is 'anti-authoritarian communities that provide ample space for side-lined voices, including self-identified parent-researchers who primarily

[50] WHO Health Ethics & Governance, COVID-19 and mandatory vaccination: Ethical considerations and caveats (13/4/2021, 2021) 1-2.
[51] ONS, n38.

employ web-based research.'[52] Yet evidence suggests that vaccine hesitancy cannot be pigeonholed so simply into the misguided being misled by the malevolent (and, fortunately for this researcher, there is nothing wrong with web-based research!). The consequentialist accounts effectively dismiss these views as morally irrelevant when they determine that the measure of whether vaccination is easy is an objective one.[53]

Views which are unreasonable from the perspective of a policymaker cannot be dismissed as of no *moral* consequence for this reason alone. Hobson-West, who has studied vaccine hesitancy, argues that most vaccine hesitant concerns are often carefully considered and arise from concern about real risks (even if they are small), including risks that may not apply to the whole group but relate to our individual differences.[54] On a deontological analysis devaluing such views is wrong as it suggests that 'our' autonomy has greater weight than 'theirs.' On a consequentialist analysis doing so is likely to add weight to 'them and us' attitudes regarding policymakers, and so may increase resistance to vaccination. Salmon et al suggested in 2015 that mandating childhood vaccinations risks driving hesitant parents to accept anti-vaccination arguments.[55] Savulescu and co-authors similarly acknowledge that mandation risks alienating patients.[56] History also supports this; the Compulsory Vaccination Act of 1853 mandated the vaccination of all English infants against smallpox. Smallpox was highly contagious, deadly, and much feared, but the vaccination was invasive and unpleasant, and carried a significant risk of adverse reactions. The issue became a rallying call for liberalism. In the Times of 1876 John Gibbs (social campaigner and founder of the Vaccination League) wrote:

> Are we to be leeched, bled, blistered, burned, douched, frozen, pilled, potioned, lotioned,

[52] Pierik n40, 383.
[53] Giubilini n31, 451-2, Savulescu, n7a 79-80.
[54] Pru Hobson-West, ''Trusting blindly can be the biggest risk of all': organised resistance to childhood vaccination in the UK' (2007) 29 Sociology of Health & Illness 198, 210-11.
[55] Daniel A Salmon, 'Making mandatory vaccination truly compulsory: well-intentioned but ill conceived,' The Lancet vol 15, August 2015, 872.
[56] Rebecca CH Brown et al, 'Passport to freedom? Immunity passports for COVID-19' (2020) 46 Journal of Medical Ethics 652.

> salivated . . . by Act of Parliament?' Are the intelligent people of this free realm to become ''abject slaves to the medical profession''?[57]

Durbach notes that there were two threads of objection, with middle class objectors focussed on the threat to libertarian principle and working-class objectors feeling they had been morally devalued by being 'pathologised as filthy and contagious.'[58]

The alternative to coercion, for these groups, is provision of honest and accessible evidence by trusted persons. This aims not to pressure individuals into assuming a duty of extremely difficult rescue, but to render vaccination an easier rescue. But persuasion takes time and effort. Savulescu points out that a slow vaccine roll-out itself increases the harms of Covid-19.[59] This is true, but as stated it is an argument for compulsory vaccination, which he does not propose. A deontological approach uses persuasion to make vaccination sufficiently easy to fall within the duty of rescue. Can it then also use coercion to oblige selfish choice - that is, those whose concern about vaccination do not exceed the level of much preferring not to have it, but who still refuse it?

II: Does the moral case for choosing vaccination justify mandating vaccination?

A. Mandation and coercion

The moral duty of individuals to autonomously choose vaccination arises from the claim that even a strong preference against vaccination is outweighed by the duty of rescue. Therefore, after weighing (in conditions of freedom), our wishes regarding the vaccine against the duty of rescue, then unless our preference against vaccination is more extreme then 'much

[57] The Times 18 November 1876, 9.
[58] Nadja Durbach. *Bodily Matters: The Anti-Vaccination Movement in England, 1853-1907*, (Duke University Press, 2004), 13, 49.
[59] Savulescu n7a, 79.

preferring against' then the morally right choice is to choose to be vaccinated.

This does not, *de facto*, establish a community right to coerce choice. Mandatory vaccination (in this context) involves legal measures intended to pressure individuals to accept vaccination which they would not otherwise choose through creation of associated incentives or disincentives - that is, through the addition of *other reasons to choose* which do not relate to vaccination itself. Both Savulescu and Giubilini have accepted that this is coercive.[60] Giubilini sees such reasons as 'rendering unreasonable those choices that individuals would otherwise have made through their own evaluation.'[61] Coercion differs from persuasion, which rather than giving individuals reasons to choose against their better judgement, uses 'influence by reason and argument'[62] to address the factors related to that judgement itself. Beauchamp and Childress see persuasion as a process in which "a person comes to believe in something through the merit of reasons another person advances."[63]

A standard ethical analysis typically suggests that 'rational persuasion is always permissible, and coercion is almost always impermissible,'[64] yet coercion is not necessarily ethically prohibited, as it may be justified by the common good. The ethical justification for mandation of vaccination that the consequentialist argument relies upon is the principle established by Mill, that coercion may be justified to prevent harm to community:

> The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection.[65]

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[60] Savulescu n7b, 11.
[61] Alberto Giubilini 'Vaccination Policies and the Principle of Least Restrictive Alternative: An Intervention Ladder' in Alberto Giubilini (ed), The Ethics of Vaccination (Springer International Publishing 2019) 67-8.
[62] Jennifer S Blumenthal-Barby, 'Between reason and coercion: ethically permissible influence in health care and health policy contexts' (2012) 22 Kennedy Inst Ethics J 345, 346.
[63] Beauchamp and Childress, n26, 94.
[64] Blumenthal-Barby n62, 346.
[65] John Stuart Mill, *On Liberty*. (first published 1859, Cambridge University Press, 2011).

Use of the law to prohibit behaviours that threaten the community, such as speeding, theft, and murder, is considered morally justifiable in every human society. Hobbes saw coercion as a necessary part of State's function:

> The nature of Justice consists in keeping of valid Covenants: but the Validity of Covenants begins not but with the Constitution of a Civil Power, sufficient to compel men to keep them.[66]

The principle that moral agents can be coerced to protect others is also accepted in deontology, with one difference. Kant saw coercion as justified only to protect the rights of others from those who do not choose morally, since in such circumstances coercion constitutes a hindrance to a hindrance to freedom:

> Right and authorization to use coercion therefore mean one and the same thing.[67]

On a deontological analysis it is therefore necessary to make a distinction between two reasons for refusal to be vaccinated. One group recognise that vaccination is a sufficiently easy duty to be morally obligatory, but do not weigh it into their judgement and instead choose selfishly, taking the option of becoming free riders (benefiting from group immunity without contributing to it).[68] The other group do take account of the duty of rescue in their judgement, but regard vaccination as too difficult to be required by it. They are effectively conscientious objectors.

The consequentialist analysis proposed by Giubilini specifically opposes conscientious objection, on the basis that objectors do not take their share of risk, and this violates a fairness

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[66] Thomas Hobbes, *Leviathan* (first published 1651, Penguin 2016), Ch 15.
[67] Kant, n21, 6:219, 6:232.
[68] The free-rider problem occurs when those who benefit from communal resources do not contribute their share. First proposed in market economics (William Baumol, *Welfare Economics and the Theory of the State*. (Harvard University Press 1952) the concept has since been applied to ethical decision-making.

requirement,[69] but he is talking about free riders as, like Savulescu, he regards the test of whether rescue is easy as an objective one. The deontological approach, on the other hand, suggests that only selfish objectors have a moral obligation to choose vaccination that justifies coercion.

B. Is bodily autonomy a special case?

It might be argued that coercion regarding invading the human body crosses a barrier that is different in nature than that which limits invasion of our other interests. In other words, we have an absolute right to reject vaccination, irrespective of our moral obligations and the harm to others.

There is no obvious reason why a moral duty should stop at the boundary of the body. Ramsey suggests that bodily autonomy is given high priority in liberal societies which prioritise personal freedoms, whilst legally obliging individuals to undergo treatments in the common good is more typical of societies which prioritise communitarian principles.[70] This prioritisation is exemplified in the US case of *McFall v Shimp*,[71] where a Pennsylvania County Court found that Shimp could not be obliged to donate bone marrow to his cousin to save his life. Flaherty J described Shimp's refusal as legally irreproachable but morally indefensible, but determined that recognising such a duty 'would defeat the sanctity of the individual, and would impose a rule which would know no limits.'[72] Is this sanctity ethically absolute?
The UK has legal precedent for compelling treatment to prevent harm to others. Section 63 of the Mental Health Act allows mentally ill individuals with capacity to be treated against their will if they are a danger to others. Doctors are ethically required to maintain immunity to common serious communicable diseases when in clinical practice,[73] as they might otherwise

[69] Giubilini n5, 7 and Steve Clarke, Alberto Giubilini and Mary Jane Walker, 'Conscientious Objection to Vaccination' (2017) 31 Bioethics 155, 158.
[70] Paul Ramsey, *The patient as person. Explorations in medical ethics*. (Yale University Press 1973), 189.
[71] 10 Pa. D. & C. 3d 90 (1978).
[72] ibid at 2 (Flaherty J).
[73] General Medical Council, Good Medical Practice (General Medical Council 2013), para 29.

infect others (a similar rationale to that now being made for Covid-19) and whilst not strictly compulsion, their registration depends on following General Medical Council (GMC) guidance. As this article was completed the government stated that care home staff will be put in a similar position when they announced that vaccination would be a condition of employment for care home staff (who do not have registration contingent on adherence to professional medical ethics as doctors do).[74] UK society therefore appears to have already established the principle that it is ethically permissible to invade bodily autonomy for the sake of the public good.

C. What level of coercion is permissible?

If our collective response to Covid-19 suggests recognition of a duty of difficult rescue which justifies coercing selfish choice, how much coercion is acceptable?

There are many options. Giubilini suggests a rank-ordering of possible interventions consists of persuasion, nudging, incentivisation, loss of financial benefits, imposition of financial penalties, withholding of social goods (societal norms), and, as a last resort, compulsory vaccination.[75] The Nuffield Council of Bioethics also created an intervention 'ladder' in which the least intrusive step was 'do nothing', and the most intrusive was to legislate to restrict liberty.[76] They suggested that 'quasi-mandatory' approaches can be ethically justified for highly contagious and serious disease if eradication is within reach.[77] However they were writing in 2007, and so did not apply this reasoning to the current pandemic.

How do we decide? Savulescu suggests that a modest penalty might be justifiable, based on the kind of penalties we appear to consider reasonable for those who do not pay tax or wear

[74] Denis Campbell, 'Covid jabs to become mandatory for care home staff in England' Guardian (15/6/21) https://www.theguardian.com/world/2021/jun/15/covid-jabs-to-become-mandatory-for-care-home-staff-in-england accessed 15/6/21

[75] Giubilini, n61, 89

[76] Nuffield Council on Bioethics, *Public Health: Ethical Issues*, November 2007, 41.

[77] Ibid para 4.27.

seatbelts.[78] He also suggests payment for vaccination, which he argues would not be coercive since it adds an option, although even modest payments may be highly influential, and indeed coercive, to those in need.[79] Moreover if almost everyone receives a payment it arguably becomes a norm, and not being paid becomes a disincentive.

Two of Savulescu's conditions for mandating vaccination are a cost/benefit profile superior to other alternatives, and a proportionate level of coercion.[80] This follows Mill's harm principle, which implies that interference with liberty should be to the least effective degree, a 'principle of the least restrictive alternative' that is regarded as central to public health ethics[81.] However it is not clear from this where the upper limits of such coercion lie - that is whether, in the event that the most coercive measures were the most effective, there is any limit to permissible coercion. Whilst excessive authoritarianism may be counterproductive, as it was when smallpox vaccination was mandated in the nineteenth century and the punishment for refusal was imprisonment,[82] times have changed, and it may be that, today, highly coercive measures might produce the highest uptake of Covid-19 vaccination. The public might even support this: conscientious objectors to military service were jailed during both world wars and the public raised little objection, albeit that the severity of the punishment was eventually challenged in Parliament.[83]

An answer may lie in a deontological analysis regarding the importance of moral agency. The Nuffield Council on Bioethics suggest, for example, that mandatory measures should not *unduly* compromise the voluntariness of consent.[84] The principle that we must consent voluntarily before doctors can invade our bodies is established in both law and ethics, and it

[78] Savulescu n7a, 83.
[79] Dave Archard and Sue Tansey, 'Getting the jab done' (Nuffield Council on Bioethics, 2020) <https://www.nuffieldbioethics.org/blog/getting-the-jab-done> accessed 4/6/21.
[80] Savulescu n7a, 78.
[81] Childress JF and others, 'Public health ethics: mapping the terrain' (2002) 30 J Law Med Ethics 170, 173.
[82] described in Durbach, n58.
[83] HL Deb 3/4/1919 vol 34 cc150-67, HL Deb 2/3/ 1943 vol 126 cc358-92.
[84] Nuffield Council n76, 4.26.

is not only the law that will determine what level of coercion is permissible. The GMC (who license UK doctors) state that doctors must be satisfied they have consent (or other valid authority) before touching a patient,[85] and must respect patients' life choices and beliefs.[86] In Germany the Standing Committee on Vaccination, the German Ethics Council, and the National Academy of Sciences Leopoldina have already issued a joint statement clarifying that compulsory vaccination is incompatible with the requirement of informed individual consent.[87] Consent is, by definition, based on voluntary choice.

Even if the State were to change the law to permit compulsory vaccination, and even if this were to survive a human rights challenge, the State cannot oblige doctors to compromise their professional ethical obligations to patients. These represent the ethics on which public trust in doctors is based and could be seen as a covenant established with patients independent of law.[88] Compulsory or even highly coerced vaccination would require an entirely different medical workforce from the one currently in place, as today's UK doctors would not be comfortable vaccinating a patient who said that they did not choose vaccination but were submitting out of fear of a punitive alternative.

What level of voluntariness is sufficient to permit doctors to act? Autonomous consent, in medical ethics, is understood to require choosing freely,[89] but freedom is a relative concept. In law, coercion is treated as binary, since a court must decide that consent is present or absent. In *Re T (Adult: refusal of medical treatment)*,[90] where a T was persuaded to refuse life-saving blood transfusion by her mother, coercion was defined as when the will of another person

[85] General Medical Council, *Good medical practice* (GMC 2013) para 17.
[86] ibid para 48.
[87] National Academy of Sciences Leopoldina, 'Recommendations for fair and regulated access to a COVID-19 vaccine', Joint position paper of the Standing Committee on Vaccination (STIKO), the German Ethics Council and the National Academy of Sciences Leopoldina on ethical, legal and practical framework conditions' (2020) <https://www.leopoldina.org/en/press-1/press-releases/press-release/press/2750/> accessed 24/5/21.
[88] Ramsey n70, 5-7.
[89] Clarified in Article 1 of the Nuremberg Code 1947: 'The Nuremberg Code (1947)' (1996) 313 BMJ 1448. See also Gerald Dworkin, 'Acting Freely' (1970) 4 Noûs 367, Gerald Dworkin, *The theory and practice of autonomy* (Cambridge University Press 1988).
[90] [1992] 4 All ER 649 (CA).

directly restricts Ps options or influences the way P chooses between them, such that their will is overborne.[91] In *The Centre for Reproductive Medicine v Mrs U,*[92] however, Mr U had revoked his consent to posthumous conception at the request of a clinic because otherwise treatment would not proceed. Hale LJ determined that, despite Mr U having revoked consent for reasons unrelated to his preference regarding posthumous conception, the revocation did not meet the legal test for coercion that Lord Donaldson had defined in *Re T (Adult: refusal of medical treatment)* [93]

Ethics is not binary. We can be coerced to a greater or lesser degree. Both Frankfurt and Feinberg see coercion as any external influence on a person's decision-making. [94,95] This would suggest that Mr U was coerced, since he did not actually make a choice about posthumous conception but agreed to strike out his signature to avoid cancellation of treatment. As Dowds points out in the context of sexual consent, a continuum of coercive acts and circumstances may impact freedom with, at the more coercive end of the spectrum, a lack of voluntariness that leaves no possibility of consent.[96] A choice between two evils is not understood as a true choice at all, as in Styron's novel '*Sophie's Choice'* (where Sophie is forced to determine which of her children will die, or else lose both).[97]

A choice between two evils would not be considered voluntary on a normative understanding of autonomy. In 1992 a Texan grand jury refused to indict Joel Valdez for the knifepoint-rape of Elizabeth Wilson because she assented to sex under threat. Members of the jury later indicated that they had understood that, in law, her assent constituted consent,[98] but the

[91] Supra 113-114 (Lord Donaldson).
[92] [2002] EWCA Civ 565.
[93] [1992] 4 All ER 649 (CA).
[94] Harry G Frankfurt, (1973). Coercion and Moral Responsibility. In Ted Honderich (Ed.), *Essays on Freedom of Action*. London: Routledge.
[95] Joel Feinberg, (1989). *The Moral Limits of the Criminal Law: Volume 3: Harm to Self.* New York: OUP.
[96] Eithne Dowds, 'Towards a Contextual Definition of Rape: Consent, Coercion and Constructive Force' (2020) 83 The Modern Law Review 35, 36.
[97] William Styron, *Sophie's choice* (Random House 1979).
[98] Peter Westen, *The logic of consent: the diversity and deceptiveness of consent as a defense to criminal conduct* (Routledge 2016), 2.

resulting public outcry seemed to confirm that this was not the normative view.[99] How much further back along the spectrum of voluntariness should we set our boundaries? There is no single, obvious point. Westen notes that autonomous choice constitutes a 'range of enthusiasms' from desire to repugnance, all of which may accompany an 'all things considered' choice.[100] Real life does not always offer perfect positive choices which we are pleased to make.

One answer that has been widely accepted as describing what we understand by autonomy is that of Gerald Dworkin, who suggests that we consider that persons choose autonomously if they are content with the reasons for which they choose.[101] This suggests that modest incentives that are seen as reasonable (such as vaccination exemption from testing in social situations), might be less autonomy-impairing than modest disincentives. Frankfurt saw this contentment as satisfying second order desires (first order desires being those by which decisions are made, and second those by which the first are judged).[102] On this basis autonomy sufficient to consider choice *voluntary* might be defined as choosing for what we normatively understand as *reasonable reasons*.

Conclusion

The individual duty to agree to vaccination arises from the duty of rescue, itself a consequence of our individual membership of, and reliance on, community. Consequentialist analysis proposing mandating vaccination suggests that vaccination is a duty of *easy* rescue because the vaccination is safe and effective, arguing that an objective determination of this is the right

[99] Carla M da Luz and Pamela C Weckerly, 'The Texas 'Condom-Rape' Case: Caution Construed as Consent' (1993) 3 UCLA Women's Law Journal.
[100] Westen n98, 28.
[101] Gerald Dworkin, 'The nature of autonomy' (2015) 2 Nordic Journal of Studies in Educational Policy 28479, 28486.
[102] Harry G Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) 68 The Journal of Philosophy 5.

one, and that principles of fairness mean that all must play the same part. They suggest that if mandating vaccination increases vaccination uptake, it is ethically justified. They suggest that interference with autonomy must be proportionate, but do not explain how this is to be determined. Therefore, whilst they accept that the interference with liberty should be the minimum necessary to achieve an effective result, they do not explain whether, if extreme coercion were to prove the most effective approach, any ethical principle prohibits this.

A deontological account suggests that the limit of the duty of rescue must be defined by the one doing the rescuing. Neither fairness nor the duty of easy rescue therefore explains why vaccine hesitant members of the community should be vaccinated or why mandation is permissible. However, an exploration of the limit of difficulty for the duty of rescue suggests that, in the current context of Covid-19, it has been established (in the UK) by *en masse* consensus (as opposed to simple majority) that this community has a duty of difficult rescue that extends, at least, to things we much prefer not to do. This suggests that the vaccine hesitant who much prefer not to be vaccinated are morally obliged to agree to it and should weigh this duty in their decision, whilst for those with greater aversion than this the duty of rescue may not demand vaccination.

The moral duty to choose to be vaccinated is a duty to exercise autonomy unselfishly, or to take proper account (when deciding) of the duty of rescue. This is not the same as a community 'right' to restrict or deny autonomy. On a deontological analysis, only coercion of selfish choices is justified, since those who choose selfishly do not recognise their moral duty of rescue when deciding, choosing instead to become free riders. For those who choose not to be vaccinated because of extreme aversion the only justifiable ethical approach is not coercion but persuasion (that is persuasion of the merits of choosing vaccination, rather than persuasion to comply for 'other' reasons), to make vaccination an easier duty. This might change in the face of clear evidence of '*en masse*' commitment to a duty of extremely difficult rescue, but until that is the case this group should be regarded as conscientious objectors.

One could argue that selfish choices in this context could justifiably be heavily coerced in the context of the pandemic, since such choices invade significant freedoms of others (even a small number of refusers may lead to Covid deaths that would not otherwise have occurred). However, even if the law permitted extreme coercion, doctors' medical ethics do not permit them to invade the bodies of patients without voluntary consent. This sets a practical limit to coercion as doctors' understanding of which decisions are sufficiently voluntary as to permit them to vaccinate. The suggestion offered here, therefore, is that the practical limit to the permissible level of coercion is that it must not exceed that which permits an 'all things considered' decision made for normatively reasonable reasons, as opposed to a choice between evils.