THE DETERMINATION OF THE BEST INTERESTS IN RELATION TO CHILDHOOD IMMUNISATION

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ABSTRACT

There are many different ethical arguments that might be advanced for and against childhood vaccinations. In this paper I explore one particular argument that focuses on the idea that such vaccinations are justifiable because they are held to be in the best interests of a particular child. Two issues arise from this idea. The first issue is how best interests are to be determined in this case. The second issue is what follows from this to justify potential interventions within the family in relation to such vaccinations. I argue that best interests must be characterised objectively in such situations and that this means that, in at least some cases, parental decision-making about vaccinating their children may be overridden.

Many childhood vaccinations are given to children at a very young age, often when they are just a few months old. A key aspect of this paper is the thought that this group of children are incompetent, and therefore not able to make decisions about their own care.\(^1\) This means that some other method of decision-making about their care needs to be in place. In such a situation one or more persons is required to make a decision on behalf of the incompetent child. The core issues are who this should be, and on what basis they should make the decision. It is generally believed that such decisions ought to be left to the parents of the child and in most cases; I believe this is perfectly appropriate.\(^2\)

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1. If we are talking about an older child then they may be competent, in which case, we should treat them in the same way as we would a competent adult (although the latter issue is not discussed in this paper).
2. I will use the term 'parents' throughout. This term is to be read as a shorthand form to include anyone holding the appropriate legal relationship of
This is, at least partly, because we tend to think that parents will make health care decisions about their child on the basis of what is in that child’s best interests. However, whilst we might assume that parents always act in the best interests of their child, this is a reputable presumption. I will argue that in at least some cases this presumption is misconceived and parental decision-making in relation to vaccination should sometimes be overridden. Such a situation arises where there is a substantial risk of significant harm resulting from the decision to either vaccinate or not to vaccinate. Justifiable cases of such interventions will seek to protect the child from potential harm with little or no risk of harm resulting from the intervention itself. In such a situation, I will argue, relevantly constituted third parties should not merely be able to exercise their powers in order to protect the child by overruling the parental decision, they are obligated to do so. My proposed justification for this view is based upon what I will term the ‘best interests argument’. This argument is intended to provide a reasoned basis for justifying the possibility of overriding a parental decision on at least some occasions and can be used to explain the nature of such justified circumstances.

It might be argued that public health issues such as childhood vaccination policies should not be discussed in terms of ‘best interests’ at all as such an approach focuses upon the individual child rather than the population as a collective body. However, I suggest there are three reasons why it is important to consider this argument. The first is that parents themselves often phrase the issue in these terms. This is perfectly understandable as parents are considering, quite rightly, whether a particular vaccination at a particular time is in their child’s best interests. A judgment about this may well take into account the prevailing facts about the rates of vaccination in the population as a whole and hence the existence or not of ‘herd protection’ for that disease in the population. Whilst parents might care deeply about the population’s health, the central focus for any parent when faced with the prospect of parent or guardian. Of course ‘parents’, where there is more than one, can disagree amongst themselves. I will ignore this issue here, and will assume for the purposes of argument that parents agree as to what is in fact in their child’s best interest in relation to vaccinations.

3 That is justified in the appropriate sense, for example, by being bound by a relevant legal duty of care or statutory duty.

a possible vaccination will surely be what they believe to be in the
best interests of their own child.

Secondly, some commentators have made reference to the
issue of best interests as being of central relevance to the argu-
ments about childhood vaccination. The idea behind this point
is presumably that both parents and professionals can agree that
decision-making about what is in the child’s best interests is the
central issue within the context of a clinical encounter. However,
precisely how best interests are to be determined in such a context
is open to dispute, and it is this issue that is discussed in this paper.

Thirdly, and finally, the courts are likely to apply a best interest
test in any relevant cases involving childhood vaccinations. This
is what happened in a recent legal case in the UK, where two
different sets of parents were in disagreement about whether it
was appropriate to vaccinate their children. The court applied a
‘best interest’ test in relation to each child and each vaccination.

However, I do not want to suggest that the ‘best interests’
argument is the only argument that is relevant to the issue of
childhood vaccinations or even that it is the most important one.
It is only one possible argument among many. However, it is one
that has not so far been explored in the literature.

The structure of the paper is as follows. In section 1, I outline
the ‘best interests argument’ itself, before considering various key
components of the argument in the next three sections. I begin
this task in section 2, where I discuss different possible senses of
‘best interest’ and argue that one particular formulation has to
be adopted in this context. In section 3, I consider the nature of
harm and how decisions about harm are to be made, and section
4 focuses upon who it is that should make decisions about child-
hood vaccinations.

against mumps, measles & rubella: is there a case for deepening the debate?’
BMJ. 323. 838–840. R. Fry. 2002. ‘Debate crystallises dilemma facing many med-
ical disciplines’ BMJ 324. 733; P. English. ‘General practitioners’ two roles are not
in conflict with MMR immunisation. BMJ. 324. 733.

See A & D and B & E [2003] EWHC 1376 (Fam) and the appeal of the
same case B (Child) [2003] EWCA Civ 1148.

This paper is one in a series that seeks to explore all of the different possible
arguments that there might be about childhood vaccination. I will therefore not
be discussing other possible arguments in favour of vaccination of children
based upon such things as the good of the community or harm to others etc
in this paper. However, for some discussion of these other arguments see A.
Dawson. ‘Therapeutic vaccines and the prevention problem’, Bioethics 2004;
18 (6): 515–530; M. Verweij, & A. Dawson. ‘Ethical principles for collective
protection as a public good: vaccination and our obligations to others’ (ms).

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1. THE ‘BEST INTERESTS’ ARGUMENT

In this section I outline, and briefly discuss, what I will call the ‘best interests argument’ for childhood vaccinations. In short the argument takes the following form:

1. Medical decisions about incompetent patients should be made on the basis of what is in their best interests (where prior wishes are unknown or non-existent).
2. Pre-school infants are incompetent (and have no prior wishes).
3. Therefore, decisions about the medical care of infants should be made on the basis of what is in their best interests.
4. Best interests in relation to infants should be determined by seeking to balance the potential harms and benefits of possible actions and inactions.
5. Where the parents make a decision about an infant’s care which is likely to result in substantial risk of significant harm to that infant then third-parties (such as the state) have an obligation to intervene to protect the infant from the consequences of that decision.
6. Given 4, what is in the best interests of infants in relation to vaccinations is to be decided by seeking to balance the harms and benefits associated with vaccination versus non-vaccination.
7. Given 3, 5 and 6, where it is in an infant’s best interests to be vaccinated (or not vaccinated) and the parents decide the other way then the state (or other legitimate third-parties) have an obligation to ensure that the infant is protected from the consequences of such a decision.

Conclusion: Parental decision-making about childhood vaccinations can be overruled legitimately in at least some cases.

There are, of course, a number of these premises that might be contested. Some of them turn upon the relevant empirical evidence, whereas others involve controversial normative claims. I will add a few notes to this outline in the remainder of this section to aid interpretation, and to defend the argument from possible objections. I will then discuss some of the components of the argument in more detail in the next three sections.

The first premise requires some explanation. Where individuals are incompetent there are generally three possible grounds for making decisions about their care. The first is on the basis of previously expressed wishes. This is irrelevant in the case of such young children as they have never been competent and have no
such views to be taken into account. The second possibility is for some sort of substituted judgement to be made on behalf of the child. This, in turn, is open to various interpretations. If the judgment is to be on the basis of what this individual would have decided if they were competent, then this too is irrelevant for the same reason that previously expressed wishes can be discounted: that is, we have no idea what such an individual would decide. If, on the contrary, the judgment is to be made in terms of what a rational person would decide then this is likely to end up being, in effect, quite close to a decision based upon best interests, which is the third possible way of making decisions for incompetent individuals. The parents of the child might argue that they are able to make a substituted judgment on behalf of the child as they are able to predict what the individual child’s views will be as it is their child. However, we might question what status this statement has. Is this just a prediction as to what the child’s views are expected to be once competent to make such decisions for themselves or is it a statement as to what the parents would prefer the child to choose if it were competent? In either case, it is not clear that this is a sound basis for decision-making. Given the fact that such young children are, and always have been, incompetent, the most reasonable grounds for decision making in such a context is, I would argue, to appeal to the idea of best interests. This avoids merely ‘guessing’ what the individual would decide if they were competent. Of course, the definition of best interests itself is a controversial issue which will be discussed in detail in section 2.

For the sake of completion we should also consider another possible option here, because we are concerned with parents making decisions on behalf of their children. This view holds that it is for parents to decide what sort of person their child will become just because this follows from the very nature of the parent-child relationship. Such a view might be based on a number of different possible justifications. For example, grounds might include the thought that parents in some sense ‘own’ their children and therefore have the right to decide what should happen to them; or that parents just by virtue of being parents decide how their child should be brought up; or perhaps, most plausibly, that the family is a private institution that is not legitimately open to outside interference in relation to the choices that will shape the child. Of course such views open up general issues about the child-parent relationship. For our purposes it is sufficient to note that we can side-step these objections because the child is an individual in their own right and parents have no absolute right
to put the child at risk for the sake of their own beliefs. Whilst any of the above points might have some merits, their absolute forms are not convincing. The supporters of such views are likely to concede that there will have to be limits upon parental authority, in at least some cases, unless they want to defend a very implausible absolutist form of their argument. This means that the argument then just returns to a more specific discussion about the criteria that are appropriate for such interventions against the parental will. A key component of this will be the determination of the risk of harm relevant to the parental decision.

The second premise is important, but I hope uncontroversial. It is important because one vital aspect of my argument is that it is focused upon a particular group of individuals who cannot make decisions for themselves, that is, pre-school children. Whilst some older (teenage) children may well be competent to make these judgments, I do not believe that children less than two can weigh up the risks and benefits of vaccination programmes. I will therefore restrict my discussion in this paper to the latter group. The third premise follows from the first and second. The fourth premise offers a suitable basis for deciding what constitutes ‘best interests’ in relation to pre-school infants. It might be controversial but this is discussed and defended in detail in section 2.

Some people might also consider the fifth premise controversial in at least some cases, although it should be noted that this is just a general claim. Even someone willing to argue that parents do have an absolute right to decide how their children should be treated, should be able to accept it. The principle behind this premise is that incompetent individuals are generally vulnerable and need to be protected from the ill-informed, reckless or negligent decisions of others. It does not really matter who functions as such a protector in any particular society, as long as someone does. It may be a role shared by the other members of society, or it might be delegated to a particular individual or agency (e.g. social services department; courts etc). This premise seeks to

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This should be acceptable even to the advocates of the greater participation of children within decision-making about their health care sure as P. Alderson & J. Montgomery. 1996. *Health Care Choices: Making Decisions with Children*. London. Institute for Public Policy Research.

This is the standard age for many existing vaccination programmes. See, for example, the suggested ages in Health Education Authority. 1997. *A Guide to Childhood Immunisations*. London. HEA

There is here a general theory of obligation at work in the background. In short, I would argue that we all have moral obligations to each other arising
justify a protective role for the state or any other relevantly constituted third party in relation to such vulnerable individuals.

The sixth premise is an attempt to apply the general principle contained in the fourth premise about the nature of best interests for incompetent infants to the specific issue of vaccinations. Although this may be held by many to be deeply controversial, it should be noted that the statement in the sixth premise is a general one, and no claim is made on behalf of any particular vaccination programme. The premise is only suggesting that in at least some (non-specified) cases it may be in the child’s best interests to be vaccinated (or not). This argument can only be applied once we have considered the nature of best interests and any relevant empirical issues in relation to the potential risk of a particular disease and the particular associated vaccination for that disease. This will be discussed in detail in section 3.

The seventh premise gets to the core of the argument and appeals to both empirical and normative elements. The claim is that where there is a high risk of significant harm to the child resulting from the parent’s decision, and an alternative choice is in the best interests of the child, then that parental decision should be overruled. Once again this is a general claim, and any application of this argument to specific circumstances will depend upon the relevant facts in relation to a particular disease and a particular vaccine. This premise assumes that where a parent refuses (or accepts) a vaccination (of an unspecified sort for an unspecified disease) on behalf of their child it is at least possible that they are not acting in that child’s best interest.11

This first section has attempted to explain the ‘best interests’ argument but, as many of these premises are open to debate, the rest of this paper will seek to justify and defend the core claims of the argument. I will focus the remaining discussion upon just three essential components of this argument in the following three sections. These are:

(a) What are ‘best interests’? How are they determined in this situation?

(b) How is the idea of substantial risk of significant harm to be understood?

from the fact we are sentient beings, but that parents are given a special set of obligations by society in relation to their children. However, these are revocable, and they should be revoked where the parents do not carry out the particular obligations (whether positive or negative) that we expect someone in a parental role to perform; for example, where a child is abused or neglected.

This general claim can be accepted even if we don’t actually know, or cannot agree upon, what is in that child’s best interests.

11 This general claim can be accepted even if we don’t actually know, or cannot agree upon, what is in that child’s best interests.
(c) Why think that the parental decision can be legitimately overridden?

2. WHAT ARE ‘BEST INTERESTS’?

It is surprising that there is so little literature about what ‘best interests’ might be, given the fact that they are invoked so often in discussions in health care, especially in relation to decisions about incompetent patients. However, there appears to be two recognisable sets of views as to what the term might mean. For the sake of simplicity I will call these an ‘objective’ and a ‘subjective’ account of best interests.\(^\text{12}\)

The advocate of an ‘objective’ account argues that the concept of ‘best interests’ is to be explained in terms of maximising the individual’s welfare, well-being or good. On this view, the action or inaction that brings about the maximisation of the relevant consideration in a particular situation is that which is in the individual’s best interests. Buchanan and Brock have produced perhaps the clearest outline of what such a view would involve. They argue that the decision arrived at can only be judged to be ‘best’ if such an action would bring about the most good for the patient.\(^\text{13}\) The idea is that this judgment about best interests can be determined independently of what the relevant individual themselves might believe or desire to be relevant to the production of their good. In addition, the true determination of best interests on this view need have nothing to do with what the majority of people might choose in such a situation. The only relevant factor is which outcome will maximise the welfare of the individual.

Such ‘objective’ accounts are, of course, going to be controversial as it means that very different competing factors will have to be assessed and weighed against each other to reach a judgment about what will produce best interests. This means that such views are open to parallel objections to those often aimed at some forms of consequentialism, such as ‘how do we do the calculations’ and ‘how do we weigh incommensurable goods’? This is not the place to explore all the objections and any possible responses to this view. The important point for my purpose in this paper is that on this view the judgment as to what is in an individual’s best interests

\(^\text{12}\) This is, of course, a simplification of very complicated issues. I say much more about this in ‘What are “best interests”?’ (ms).

is to be determined by the outcome which would maximise welfare even if we are ignorant or mistaken about which outcome that might, actually, be. This means that on such a view, allowance can be made for the fact that someone either gets the calculations wrong or abuses their position in making such a decision, say, by deciding what is in their own interests, rather than genuinely in the best interests of the relevant party. However, whilst such distortions can occur, they do not take away from the fact that there is an answer as to what will maximise welfare even if we are not clear what it might be.

The advocate of the ‘subjective’ account of ‘best interests’, by contrast, holds that the concept is to be defined in terms of what the individual themselves does choose, or if they are incompetent, what they would be expected to choose if they were able to do so. This view might take two forms. It might be that a moderate form argues that where knowledge is available of an individual’s views, these are taken into account when judging ‘best interests’ for that person in that situation. Or a more radical form might be that what an individual believes is in their best interests, where known, is what is in their best interests. The moderate view should perhaps be seen as a way to emphasise the role that autonomy might play in judgments about best interests. The idea here is that if I value certain types of, say, religious beliefs then actions that fail to take account of these will tend not to be in my overall best interests precisely because my beliefs have been ignored. The more radical view seems more focused on making an epistemic point rather than one about the relative priority of autonomy in an assessment of best interests. The radical view captures a certain type of scepticism about the possibility of identifying best interests independently of what the individual concerned believes to be in their interests. We might describe this scepticism as a variety of a more general form that argues that we have no independent access to metaphysical facts beyond what we believe about them. On this view, as the central issue is what might be in your best interests, and you have the clearest access to your experiences, you have the decisive role in determining what is in your interests.

However, how is this theoretical discussion about best interests relevant to the core issues of this paper? In this case, of course, someone else is making the decision on behalf of the infant because the child is incompetent. Such a decision cannot be made on a ‘subjective’ basis, as we have no insight into the relevant party’s beliefs as they do not have any that are sophisticated enough to count. It might be made on the basis of the parental ‘subjective’ beliefs but it is not clear that this would reflect a ‘best

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interests’ standard at all. When making decisions on the basis of best interests relative to an always-incompetent individual, the only way to make a decision in their best interests is to use an objective test. Therefore this allows us to sidestep many of the difficulties associated with the arguments about the relative merits of subjective and objective accounts of best interests because only an objective test is available in this type of case. We will leave open for the moment what sorts of factors will play a key role in the decision about best interests in relation to childhood vaccinations and we’ll come back to this after discussing the issues in relation to harm in more detail in the next section.

However, it is worth noting that an objective determination of ‘best interests’ for infants is likely to focus on a number of key issues. Buchanan and Brock (1989: p. 247) usefully distinguish between what they term ‘current interests’ and ‘future-orientated interests’ of the child. The reason to mark the distinction is that the two can come into conflict. Current interests are largely formulated in relation to experiential considerations, whereas future-orientated interests are focused on developmental considerations.¹⁴ For example, the idea is that the performance of an operation may impact upon current interests (through the production of pain) but this is not enough to count against the intervention if it can be justified through the promotion of longer-term interests (perhaps by ensuring that the child can participate in a wider variety of physical and social activities as a result).¹⁵ When we consider the future-orientated as well as the current interests in any assessment of best interests we will, rightly, be tempted to assign great weight to harm prevention considerations. This will be particularly true where decisions will have a likely significant impact upon the child’s future development, such as when the potential harms may result in death or serious long-term or permanent injury.¹⁶ On this view then risks of health-related harms might well play a key role in judgments about best

¹⁴ Clearly, in relation to infants these future-orientated interests are very important. They are the type of thing Feinberg calls attention to in: J. Feinberg ‘The Child’s Right to an Open Future’, in Freedom & Fulfillment: Philosophical Essays, Princeton, NJ: Princeton University Press.

¹⁵ This is, of course, true of adults as well. However, the difference lies in the fact that some decisions made on behalf of children will close off various options in later life in a way not true of adults. This is because children have various non-actualised developmental interests that need to be protected.

¹⁶ It is worth noting that in cases involving the serious risk of such harms it is no good merely to state that the child can review the situation themselves once they have obtained a suitable threshold of competence, since as a result of a parental decision the potential harm might already have occurred.
interests although we cannot simply move from an assessment of medical best interests to best interests per se.\textsuperscript{17}

3. THE ANALYSIS OF SUBSTANTIAL RISK OF SIGNIFICANT HARM

The ‘best interests argument’ is a general argument, but it will only be applicable in the real world once we consider both a particular type of disease and the relevant vaccination that is available to combat that disease. This is because the argument as a whole is dependent upon the idea of the relative risk of harm produced through two incompatible decisions (to vaccinate or not vaccinate).\textsuperscript{18} A sound judgment cannot be made in the abstract, but only in the light of the relevant and available empirical evidence. Where we have an incompetent patient with no previously expressed wishes the only way health care decisions can be made is on the basis of what is in that individual’s best interests. This, in turn, is to be decided by judging which action or inaction will bring about least harm and the greatest overall good.

This is again a controversial claim as it might be held that there is a moral difference between seeking to minimise harm, on the one hand, and promote good, on the other. The thought here is that, using the language of the four principles, non-malfeasance takes priority over beneficence. This might be used as an argument against third-party non-parental sponsorship of vaccinations because it is claimed that such acts are focused upon intentionally promoting the best possible good, whereas parental refusal is seeking to prevent harm, therefore the latter should take priority. Such an argument is not convincing, of course, because even leaving to one side the issue of non-malfeasance supposedly taking precedence over beneficence,\textsuperscript{19} the harm likely to arise as a result of non-vaccination may be greater than that likely to be caused by the vaccination itself. However, in this case we can avoid the debate over the strict relation between beneficence and non-

\textsuperscript{17} I am very grateful for the comments of an anonymous referee for prompting improvements in this section.


\textsuperscript{19} There is no good reason to do this, of course, because the assessment should be done in terms of both harms and benefits, not merely on harms. Personally, I see no reason to justify prioritising either harms or benefits in decision-making.
malfeasance because the issue can be assessed either in terms of preventing harm (this can be accepted as a fundamental value e.g. non-malfeasance) or as part of promoting the good (beneficence). This means that even if someone wishes to concentrate only upon harms in relation to this issue, it is still possible to construct a strong argument in favour of vaccination in at least some cases, or so I will argue.

If we choose therefore to focus upon harms, we still need some way of weighing the relative risks of different harms against each other. How should we do this? I suggest that it is reasonable in such circumstances to weigh up objectively both the likelihood of the risks occurring and the magnitude of those risks. This is in line with standard risk assessment strategies. Both factors can be most clearly seen to be relevant to the issue of vaccinations if we consider some examples. These cases are intended to illustrate how the issue of risk of harms associated with vaccination or non-vaccination may be relevant to decision making about whether vaccinating a particular child for a particular disease is in their best interests or not.

Consider the three following cases:

(a) **Blue Spot Disease.** This (fictitious) disease results in a mild rash of small blue spots on the skin but with no other consequences. A (fictitious) vaccination is available, but carries a high (<10%) risk of causing breathing difficulties and a lower (<1%) risk of death.

(b) **Yellow Fever.** This disease is fatal in a significant number of cases (ranging from 5% to over 50%). It is confined to just a few places in the world and an effective low risk vaccination is available. However, let’s pretend for the purposes of the argument in this paper that it is prevalent throughout the world.

20 It might be argued that the assessment of such risks necessarily involves some evaluative element. To some extent this is true. However, I would argue that we should not give up on the importance of the distinction between the likelihood of a harm occurring (the probability of the harm) and what such an occurrence might mean to me (the meaning of the harm). The idea, here, is that the likelihood of a risk occurring might be very low but I choose to prevent that risk occurring because the consequence would be significant to me.


Measles. This is a highly contagious disease which as a result of complications can cause serious permanent medical problems and, in at least some cases, death. A vaccination as part of the Measles-Mumps-Rubella (MMR) vaccine is widely available, but the relevant evidence for its effectiveness and the risk of causing harm are contested.

I suggest that if faced by the facts as outlined above in these three cases it would be clearly in the child’s best interest to have the Yellow Fever vaccination, not have the Blue Spot vaccination, and the measles case will be the most difficult to decide. However, it can be argued that whether or not this third possible vaccination is in the best interests of the child needs to be determined in exactly the same way as the others. In all such cases, anyone trying to decide what is in someone’s best interests in relation to these possible vaccinations should ask the following questions. What is the evidence of the risk of harm resulting from the vaccination? What is the likelihood of it occurring and how significant are these potential consequences? However, such questions need to be weighed against the likelihood of contracting that infection and the potential harm caused by the relevant illness itself.

Whilst it can be conceded that the empirical evidence in favour or against a particular medical procedure is never likely to be conclusive, this does not mean that we cannot formulate best interests judgments in relation to such issues. Indeed making
such judgments in the light of provisional evidence is most likely to be the standard case. However, where the evidence is contested or unclear, it is especially important that it is judged fairly and dispassionately. There are two main potential threats to this being achieved. The first threat to a fair judgment is a lack of relevant information, and the second threat is the factors that can bias a judgment in a particular direction. The first can be dealt with by ensuring that the decision makers have all of the relevant information. The second is more difficult to counter but where potential psychologically-distorting factors are known about these can be taken into consideration when information is provided. A decision that weighs the evidence of the relevant relative risks of harm, without any of the potential elements that might lead to a misjudgement, will be a vital component of any judgment as to what is in the infant’s best interests. In most cases the parents’ judgment as to what is in their child’s best interests is likely to be accepted. However, there must always be a residual obligation of the state to review such decision-making if necessary. It is to this issue that I now turn.

4. SHOULD PARENTAL DECISIONS BE OVERRULED?

Is there a role for the state, or some other relevant third-party, to step in to protect the child from at least some parental decisions? The vast majority of people will accept that some parental decisions should be overruled but the difficulty is determining when this should be the case. In the UK such powers have been used in a number of situations, such as the overruling by the courts of parental refusal of treatment for their children on the basis of parental beliefs, or the fact that education is compulsory whatever the views of the parents. Of course, the mere fact that there are such cases where parents are overruled does not on its own justify such an approach. However, we can ask whether there is anything that might be considered to be more systematic behind such judgments? On what basis should such decisions be made? Can a coherent and justified basis be given for them? The relevant underlying principle is that children should be protected


27 See, for example, Camden London Borough Council v A, B, C (By her Guardian ad Litem) [2000] 2 WLR 270, and Re A (Children) [2001] 4 all ER 961.

28 See Education Act 1996, s.8.
from significant harm, or even the risk of significant harm where there is a high risk of it occurring. This principle can be seen at work in the dramatic case of child protection legislation as well as in the cases cited above. In these situations third parties will make the judgment that parents are not acting in their child’s best interests. The types of considerations they will take into account are not just the scale and likelihood of the risk of harm, but also whether the parents are making a sound assessment of any relevant evidence. If there is, in turn, evidence of negligence or recklessness in the decision making process this will count against the parents. The third parties will also consider what the likely consequences of the parent decision might be. Where the decision is likely to have a detrimental impact on the child’s future development or quality of life this will play a major role in the justification for overruling the parental decision.

Clearly the state does play some role in protecting the child against parental decisions in such situations. Is it appropriate in the vaccination case? In at least some cases it surely is. If we are considering vaccinations, then I suggest the key relevant factor is the relative risk of harm (and any benefits) resulting from the potential vaccination or non-vaccination. Here there is a need to weigh the magnitude of the risk and the likelihood of that risk occurring in cases of actions and omissions. Once again, the decisive factor is the relevant empirical evidence. For example, in the yellow fever case, the state might be more strongly justified in stepping in to insist the infant is vaccinated than in some other cases where the balance of risk is unclear or finely balanced. Where the balance of risk is unclear or finely balanced there is a strong argument for saying that the state should not intervene given, in turn, the risk of harm to the parent–child relationship, linked to such interference by the state. This might be referred to as the ‘good faith’ defence. Where parents have taken a ‘reasonable’ decision (that is they are able to provide publicly defensible reasons for their decision) it is unlikely that the judgment will be made that interference in relation to that decision is

30 A good example of the way these considerations are weighted in a real case is provided by the previously cited A, B, C case [2000], which involved the risk of transmission of HIV through breast-feeding.
31 I assume there is no relevant moral difference between the two when assessing what outcome is in the best interests of an incompetent individual.
32 Or insist the infant is not vaccinated in such cases as blue spot disease perhaps.

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justified on the grounds of best interests even if a different conclusion would be reached by the relevant third parties. However, where it is clearly the case that vaccination is in the best interests of an infant it can be argued that the state has a role to ensure that its public health policies take this child protection issue into account by legislative action such as ensuring that, if necessary, childhood vaccinations are compulsory on the grounds of the best interests of the child.33

In conclusion, the state should play a role in protecting children from parental decisions in at least some cases. The hard fact is determining exactly when this should occur. It is relatively easy in some cases to decide to intervene or remain detached whereas, in other cases, it is difficult to decide where the balance of best interests might lie. However, the relevant issue is what is objectively in the child’s best interests, and a key component of this judgment is going to be the relevant empirical evidence.34 When evidence is lacking as to what is in a child’s best interests, there is an urgent need to seek it. Where a parent’s decision in relation to a vaccination is held to be negligent or reckless, and there is a high likelihood of significant harm resulting from that choice, then the state should have a residual power to step in to secure what is in the child’s best interests. In reality this is likely to be a rare event.35

Moreover, it might be objected that the proposed ‘best interests’ argument is paternalistic. This, of course, is true. However, this on its own is not an objection, unless it can be demonstrated that it is not only paternalism, but also an unjustifiable form of paternalism, and is thereby wrong. My thought here is that even liberals and libertarians may allow that so-called ‘weak paternalism’ may be justified.36 ‘Weak paternalism’ can be defined as being, an intervention motivated by the beneficent wish to prevent harm resulting from an individual’s non-autonomous decisions. Whereas ‘strong paternalism’ is held to be, an intervention motivated by the beneficent wish to prevent harm resulting from

35 This point is likely to be strengthened once the ‘harm to others’ considerations are added in.
34 Not just about the effectiveness of the vaccination and the risk of side effects, but also about other considerations I’ve chosen to ignore to simplify the argument such as what the percentage uptake for a particular vaccination is within a population might be etc.
35 However, see the legal case, mentioned earlier, in footnote 6, where this was the relevant legal test.
decisions even when an individual is autonomous, informed and acting in a voluntary manner. In the case of an incompetent infant we are talking about weak paternalism, as a child less than two has no autonomy to overrule. The justification for such weak paternalistic intervention is largely one of appealing to the best interests of the incompetent individual. As we have seen above this is a difficult and perhaps controversial judgment, but this can be the only basis for such a decision in relation to infants. The onus is on the objector to such a policy to explain why, where the intention is to ensure that decisions about the care of children are made in their best interests, such interventions are not just paternalistic but also wrong.\textsuperscript{37}

CONCLUSION

There are many different arguments that can be discussed in relation to childhood vaccinations. In this paper I wish to put to one-side arguments that appeal to things like harm to others or the good of the community or the common good. Is it possible to formulate and defend an argument for childhood vaccinations that rests upon an appeal to the ‘best interests’ of a particular child in at least some cases? I believe that it is, and have sought to argue this in this paper. If this is accepted, then intervention against parental wishes is justified in at least some possible vaccination cases, and this may form the basis for public health policies that enforce compulsory vaccinations for at least some diseases.

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\textsuperscript{37} As an anonymous referee suggested it might be possible to argue that the state is, here, acting paternalistically upon or through the parents. If this is the case the justification for the action might switch from an appeal to paternalism to a more general ‘harm prevention’ principle in the light of the perceived negligent decision of the parents.
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