Warring Autonomies: Vaccine Mandates for Healthcare Workers and the Competing Rights of Patient and Healthcare Worker Autonomy in Pandemic Policy

Tyler Paetkau

McGill University

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Abstract

The Covid-19 pandemic brought to the fore tensions between the rights of healthcare workers (HCWs) and the patients they care for. Nowhere are these tensions more evident than in debates over the right to autonomy and whether these rights allow HCWs to refuse vaccination. In the following, I argue that while both parties have a right to autonomy, the patients right to autonomy generally overrides that of the HCW. Still, the patient’s rights do not necessarily entail that HCWs possess a duty to be vaccinated. Instead, it entails that HCWs take reasonable actions to respect the autonomy of the patients.

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Introduction

The Covid-19 pandemic brought to the fore tensions between the rights of healthcare workers (HCWs) and the patients they care for. Nowhere are these tensions more evident than in debates over the right to autonomy and whether these rights allow HCWs to refuse vaccination. In the following, I argue that while both parties have a right to autonomy, the patients right to autonomy generally overrides that of the HCW. Still, the patient’s rights do not necessarily entail that HCWs possess a duty to be vaccinated. Instead, it entails that HCWs take reasonable actions to respect the autonomy of the patients.

Autonomy and Medical Ethics

At its most basic level, autonomy can be defined as “self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice.”1 While the right to autonomy is central in modern medical ethics, this is a relatively recent development. Although not altogether absent in historical approaches to bioethics, substantive discussions on the topic in North America only gained steam in the 1970s.2, 3 Prior to this time, medicine was dominated by a paternalistic style where doctors acted as they saw best with little concern for the patient’s wishes. In the worst cases, this resulted in actions such as the Tuskegee Syphilis Study, forced sterilization of women, and medical experimentation on prisoners. Many of these actions were undertaken without the patient’s knowledge or consent, and the well-being of patients was seldom safeguarded. Instead, these actions were justified by dubious appeals to the benefits to public health, science, or broader society.

In response to revelations of medical research abuses, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created in 1974.4 The commission, in turn, produced
the Belmont Report, widely considered to be one of the founding documents of modern bioethics. It is little wonder then that the Belmont report places a heavy emphasis on the respect for autonomy with its insistence that “subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them.”

Key to the exercise of autonomy are the twin conditions of liberty and capacity. For an action to be truly autonomous, it must be free from undue influence or coercion (liberty), and the agent making the decision must have the information and capabilities necessary for making a reasonably informed decision (capacity).

HCW Autonomy

While the Belmont Report focuses on human research subjects, HCWs also possesses a right to autonomy. Included in this is the right of the HCW to exercise autonomy over what enters their body and whether they receive medical interventions such as vaccines. However, this right is not absolute. For any individual in society, one commonly cited limit is the harm principle proposed by John Stuart Mill. This principle holds that:

“[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. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.”

If an being unvaccinated increases a patient’s chances of infection, it seems clear that vaccine refusal on the part of HCWs violates the harm principle. However, for HCW, the choice is often not one of merely between being vaccinated or upholding their bodily sovereignty. Instead, deep conflicts may arise from an HCW's role as what Daniel Sokol describes as “multiple agents.” HCWs are not merely HCWs. Rather, they are parents, community members, friends, etc. Each of these roles comes with a set of rights and obligations. Often, these roles will conflict with the HCW’s duties towards their patients. In such cases, the HCWs right to autonomy gives them a degree of control over what obligations to uphold. As such, how far an HCW must go to benefit their patients is “also defined by the strengths of competing rights and duties.”

One such case is raised by Doug McConnel in his discussion of the tension between the HCWs duty of care and their duty to their family. McConnel argues that during a pandemic, HCWs with family members in the same household may be justified in neglecting portions of their duty of care in order to protect their families. HCWs have a duty to protect their households from infection. Since working as an HCW during a pandemic risks passing the infection to their household, the HCW has the competing duties of serving their patients and protecting their household. Of course, McConnel acknowledges that the validity of this choice is constrained by factors such as the level of infection risk, alternatives for protecting the family, and the role of the HCW in the healthcare system. Still, he holds that there exist cases where HCWs are justified in protecting their families over serving their patients.

Patient Autonomy

As the more vulnerable party in the healthcare relationship, most discussions of autonomy in healthcare focus on the rights of the patient. For Eric Cassell, the primary function of medicine is to restore and preserve the patient’s autonomy. As a patient, the individual’s control over their body is inherently reduced. They are seeking healthcare because there is something harmful happening to their body beyond their power to control. Often, these medical issues further limit autonomy by limiting one’s ability to communicate or otherwise navigate the world. Thus, part of the duty of HCWs’ is to preserve and restore the patient’s autonomy.

In addition, the patient’s interests impact the moral character of an HCW’s exercise of autonomy. By refusing vaccination, the HCW acts against the interests of the patient in avoiding infection and receiving care from a healthy HCW. Patients have a right not to be exposed to unnecessary risk while receiving
Moreover, they have the right to understand the risks to which they are exposed and make an informed decision as to whether to be exposed to them. Some gone so far as to propose that patients may have a right to a fully vaccinated care team. In each of these cases, the right to autonomy of the patient limits the exercise of the HCW’s right to refuse vaccination.

A patient’s right to autonomy also holds special weight due to the limitations imposed on the patient. During a medical crisis, a patient faces minimal options. They can either seek medical intervention or risk dying without it. Many medical conditions requiring inpatient treatment increase the vulnerability to and severity of outcomes from a Covid-19 infection, such as how a cancer patient receiving chemotherapy has a reduced immune system. Here the patient’s autonomy is constrained by their circumstances, and they have no choice but to be made vulnerable. By contrast, the HCW has a much broader array of options.

Adding to these considerations is the weight of past decisions. When HCWs autonomously choose to take on the role of HCW, they limit the scope of future autonomous decisions. Such arguments hold that “because ultimately the health care worker has more choice about being in the hospital than his or her patient, the onus to be accommodating weighs more heavily on the health care worker.” Similarly, autonomously taking on the role of HCW entails acceptance of a certain level of risk. In other areas, HCWs are not permitted to decline to benefit their patients despite the risk to the HCW such as how HCWs are not permitted to decline to operate on an HIV positive patient. If the risks associated with vaccination are equal to or less than those HCWs regularly consent to in the line of duty, it may be that an HCW’s duties to their patients require the HCW to accept vaccine-associated risks.

Central to both arguments is that HCW made an autonomous decision to enter the profession. The role of an HCW carries obligations and limitations that restrict exercises of autonomy that may be appropriate in other contexts. By entering employment as an HCW, these individuals consent to these obligations and constraints. Moreover, some hold by entering the profession, HCWs agree to reasonably foreseeable risks. While there may be no ongoing bioterrorism attack or pandemic when the HCW enters the profession, it is easy for the HCW to consider that potential future and the risks that their chosen profession would entail in that scenario.

A severe outbreak of an infectious disease such as Covid-19 was reasonably foreseeable. In the 21st century alone, HCWs have had to contend with the 2002 SARS outbreak, the 2009 H1N1 pandemic, and the 2014 Ebola outbreak. As such, it was reasonably foreseeable that taking on the role of an HCW entailed agreeing to the risk of working during a pandemic. In turn, consenting to work during a pandemic involves consenting to the interventions used to mitigate and control the spread of disease. Vaccination is one such intervention.

Furthermore, many, if not most, health authorities already mandate certain vaccinations as conditions of employment. In Canada, health authorities in Ontario require HCWs to demonstrate “evidence of immunity for certain communicable diseases such as measles, rubella, varicella, and tuberculosis.” Similarly, British Columbia mandates several vaccines for HCWs as a condition of employment. While specific requirements differ, vaccination as a condition of employment for HCWs is relatively standard. As such, accepting vaccination is already a part of the mixture of risks and benefits to which HCWs consent when they enter the profession. New pandemics and, therefore, new vaccines are a reasonably foreseeable risk. Since becoming an HCW involves consenting to reasonably foreseeable role-related risks, HCWs can be understood as consenting to new vaccinations with a sufficiently favourable risk/benefit profile.

**Autonomy in Context**

When taken together, the weight of considerations of the patient’s autonomy overrides the rights of HCWs to refuse vaccination on the grounds of autonomy. The rights of the patient that stem from a right to autonomy entail certain duties on the part of HCWs. In particular, HCWs have a duty to protect and promote patient autonomy. Key to fulfilling this duty is protecting patients from preventable infections and ensuring HCWs are healthy enough to serve in their professional roles. Vaccination is a clear tool for fulfilling these duties.

However, while this may generally be the case, there will be HCWs for whom their competing duties are
similar or greater weight than their duties to their patients. An HCWs right to autonomy is in part a right to choose which duties to uphold. Of course, there are circumstances where it would be neglect for an HCW to disregard a significant duty to a patient in order to uphold a minor duty to self or family. Still, vaccination is not clearly one of these cases. From issues of conscientious objection to concerns over being evicted if one falls behind on bills due to vaccine side effects causing one to miss work, for some HCWs, there exist competing duties which fall within the range of being an acceptable alternative duty to uphold.

These alternatives are made all the more reasonable due to the fact that the duties entailed by the patients right to autonomy are multiply realizable. That is, vaccination is only one of several avenues for fulfilling these duties. Alternative interventions such as personal protective equipment have been shown to be as good or better than currently available vaccines both at protecting HCWs from infection and preventing transmission between HCWs and patients. As such, there exists alternatives for fulfilling the duties that derive from the patient’s right to autonomy. While these alternatives have no impact of the requirement for HCWs to fulfill their underlying duties, they considerably weaken the case for vaccination as a required act. Since HCWs can fulfill their duties through other avenues, it may be unreasonable to expect or require HCWs to be vaccinated.

Of course, it may be that taking reasonable steps to fulfill these duties requires using alternative interventions in addition to vaccination. In part this is an ethical question of what constitutes an acceptable threshold of protection so that HCWs can be said to be taking reasonable steps to fulfill their duties. However, in large part it is also an empirical question which rests of the efficacy of each intervention. If new vaccines were made available that were dramatically more effective than PPE or if the situation were to change to make PPE less effective, the justification for requiring vaccination would be strengthened. Still, this does not appear to be the current situation in regard to Covid-19.

Finally, there is the issue of other duties. Autonomy is only one of several aspects of the HCWs duty of care. Other commonly cited aspects include but are not limited to, duties of beneficence, non-maleficence, and justice. Each of these factors will add weight either for or against the argument that HCWs need to be vaccinated. Still, when it comes to considerations of autonomy, it is clear that while HCWs have a duty to protect and promote the autonomy of their patients, under current circumstances this duty does not entail a duty to be vaccinated.

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