Social Distancing and the Unvaccinated

If a state allows parents to obtain religious exemptions from vaccination requirements for school entry, can it temporarily exclude unvaccinated children from school during an outbreak of a vaccine-preventable illness without violating the family's constitutional rights? If parents refuse to vaccinate their children, what can physicians legally and ethically do to protect other patients in their practice from exposure to vaccine-preventable illnesses?

In January 2015, a federal appeals court answered the former question with regard to New York State law on immunization for school enrollment, upholding the state's authority to bar unvaccinated children from school during outbreaks, even if doing so overrides a family's religious freedom with regard to vaccination.¹ Physicians nationwide are facing the latter question as they respond to the measles outbreak that began at Disneyland in California in December 2014 and had spread to at least 17 states, Canada, and Mexico by late February.² Both questions invoke the legal and moral authority to use a classic public health measure known as social distancing to attempt to mitigate the spread of an infectious disease (see table). Nevertheless, trade-offs between personal freedom and public health are implicit in such measures. Governments and physicians employing social distancing policies must give careful and systematic attention to the ethical and legal issues.

Under the Constitution, states have police power to protect the public’s health, welfare, and safety. A long-standing use of this authority is to protect communities from risks related to vaccine-preventable illnesses. In addition, when an infectious-disease outbreak occurs, states may use their police power to interrupt further transmission of the disease by restricting the movement of individuals. All states have incorporated this concept of social distancing into their school immunization laws. Schools can prohibit an unvaccinated child, who is more susceptible to acquiring highly infectious vaccine-preventable illness and more likely to become a carrier and vector for it, from coming to school until the danger subsides. Such measures, coupled with ready availability of vaccines, reduce the potential spread of serious disease in a vulnerable and tightly packed community.

In the recent case, Phillips v. City of New York, New York’s social distancing policy was challenged...
PERSPECTIVE

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Examples of Social Distancing Measures for Controlling Vaccine-Preventable Illnesses.

<table>
<thead>
<tr>
<th>Type of Measure</th>
<th>Individual Level</th>
<th>Population Level</th>
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<tr>
<td>Voluntary</td>
<td>Avoidance of face-to-face contact</td>
<td>Cancellation or rescheduling of mass gatherings</td>
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<td>Use of sick days</td>
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<td>Nonvoluntary</td>
<td>Exclusion from school or day care</td>
<td>Closure of schools, day-care centers, workplaces</td>
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<td></td>
<td>Patient dismissal</td>
<td>Travel restrictions and border control</td>
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<td>Bans on mass gatherings</td>
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After the children of two families with religiously grounded vaccination exemptions were excluded from school for a period of time after a fellow student tested positive for chickenpox. Finding the vaccine policy “well within the State’s police power,” the Second Circuit Court reiterated the Supreme Court decision in the 1905 case Jacobson v. Massachusetts, which clearly found vaccine mandates constitutional. The court also cited the Supreme Court decision in a 1944 case, Prince v. Massachusetts, which supported limits to religious freedom if an individual’s expression of liberty risked putting his or her child or the community at risk for harm or ill health.

The scope of state public health laws, and state immunization policies in particular, may continue to be challenged. However, the Phillips case, with its focus on a core First Amendment right and a relatively mild vaccine-preventable illness, affirms the long-held axiom that the state can use its police power in ways that supersede religious and parental preferences, and somewhat burden individuals, to uphold our societal responsibility to use reasonable measures to protect against infectious-disease outbreaks.

Although exclusion measures represent a legitimate use of police power when a reasonable health threat exists, more subtle legal and logistic questions remain. Who — state health departments, school principals, or both — has the power to order school exclusion, using what criteria, and for what period? What disease threats should trigger school exclusion, and how should thresholds vary among diseases? What should the penalties be for noncompliance? Clearly, standards for necessity and proportionality should be followed, including seeking voluntary compliance and avoidance of premature imposition of exclusions, extension of exclusions beyond the end of a crisis, and imposition of restrictions that are ineffective at reducing transmission. Furthermore, the cost of restrictive policies will be borne most heavily by people with the fewest resources, so errant social distancing actions have implications for distributive justice.

Meanwhile, the court’s discussion in the Phillips case of the deference that courts give to legislative determinations regarding a state’s use of its police power reveals another way in which public health could be imperiled. The plaintiff families tried unsuccessfully to get the court to consider whether vaccines cause the public more harm than good. In its decision not to address that question, the court pointed again to Jacobson, stating in part that “that is a determination for the legislature.” The implication is that if a legislature were convinced by inaccurate information, it could enact harmful public health policies founded on that misinformation. This possibility reinforces an important responsibility of public health experts to actively engage in the policymaking process, educating legislators and regulators about the health and safety benefits of public policy informed by robust science.

Beyond participating in such educational efforts, what can individual physicians do to help with social distancing to limit the spread of vaccine-preventable illnesses? Although physicians are legally able to deny services to unvaccinated patients in most situations, most medical professionals would probably agree with the American Academy of Pediatrics that such an extreme option should be avoided. Such an action would deny an unvaccinated child access to a range of medical services and ongoing health education and would sow distrust in not only the family refused care, but also the family’s broader social network.

Instead, providers may consider other alternatives, including but not limited to establishing triage protocols for unvaccinated children (e.g., preliminary teleconsults before clinic presentation) and reserving appointments at the end of clinic hours. Such measures may enable physicians to continue their respectful and
Tuberculosis among the Homeless — Preventing Another Outbreak through Community Action

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Over the past 20 years, when the United States has seen substantial tuberculosis outbreaks, they have frequently originated in homeless shelters in cities such as Atlanta, Jacksonville, Los Angeles, and Seattle (see graph). Although such outbreaks have fortunately been contained through immediate implementation of surveillance measures, the lack of dedicated policies on treating homeless people with latent tuberculosis infection means that there’s a high risk of recurrence. The Centers for Disease Control and Prevention advocates targeted screening and treatment of latent tuberculosis infection in high-risk populations, which include close contacts of people with active tuberculosis, immigrants from regions where tuberculosis is endemic, homeless people, and those with immunosuppression. Because of financial, logistic, and outreach barriers, however, there is a wide gulf between such recommendations and current policy. Hampered by severely limited funds, local health departments must focus on cases of active tuberculosis, contact investigation, and treatment of high-risk immigrants. Often, homeless people are left untreated when latent infection is discovered on a medical exam required for admission to a shelter. Whereas in the past, public health officials cited a lack of funding and resources for treating such infections among the indigent, the Affordable Care Act (ACA) has changed the landscape. Thanks to the enhanced affordability of both Medicaid and private insurance, some U.S. patients living below or near the poverty line have been able at least to get on waiting lists for primary care appointments. Access to primary care is essential for patients undergoing treatment for latent tuberculosis infection, since a primary care provider should oversee such treatment and monitor side effects.

In our experience in Seattle, initiatives designed to provide health care for the homeless have been able to reach a broader segment of our indigent population, in both shelters and public housing, as a result of expanded Medicaid eligibility. The expansion has created an opportunity for our clinical team to screen for and treat latent tuberculosis in this population.