

Medical Advice and Vaccinating: What Liability?

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Abstract:

Outbreaks of vaccine preventable diseases have increased over the last years. This is due in large part to the growth of the number of people who choose not to vaccinate their children. This article focuses on the role of the doctor and the doctor's advice in making the decision to vaccinate or not. In some circumstances, a doctor should be liable if an unvaccinated patient contracts a disease and is harmed herself or infects others. The starting point of the article is that vaccination is recommended by professional organizations, supported by a majority of physicians, is the safer course, and hence advising to vaccinate on schedule is the standard of care. Given that, the article argues that doctors advising vaccination should not be liable if parents reject that advice. In contrast, doctors who do not recommend vaccination should be liable. This includes both doctors that passively accept a decision not to vaccinate and doctors who advise against regulation, though the latter are more culpable and may be subject to higher liability.

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Introduction:³

In response to a measles outbreak in Disneyland and criticism directed at him for his role in it, Dr. Robert (Bob) Sears⁴ wrote a post downplaying the risks of measles, suggesting its rate of fatality in the developed world was “close to zero.”⁵ This in the face of evidence of fatalities in Europe in recent years and in the period of 2003-2009 thirty one children in Germany were treated for a fatal, incurable measles complication called subacute sclerosing panencephalitis (SSPE), dying slowly.⁶ This was not the only inaccuracy in his post.⁷

Previously, in a Facebook post during 2014, Dr. Sears said:⁸

“EVERY single year in the U.S. we have measles - between 50 and 150 cases. Last year there were two large outbreaks - 58 cases in New York and over 20 in Texas. Both those outbreaks died out. **No one has died**

³ We are grateful to Rob Schwartz, Alice Warning Wasney,... for their very helpful comments, to David Coolidge for excellent editing work and to Katelyn Phillips for her wonderful research assistance. All errors are, of course, our own.

⁴ Dr. Bob Sears is son of Dr. William Sears, an influential physician and author of a series of books. He is known, among other things for his book – Robert W. Sears THE VACCINE BOOK: MAKING THE RIGHT CHOICE FOR YOUR CHILD (2007). Dr. Sears’ book were discussed in Paul A. Offit, DEADLY CHOICES: HOW THE ANTI-VACCINE MOVEMENT THREATENS US ALL 171-190 (2011).

⁵ Dr. Bob Sears, FACEBOOK.COM (January 16, 2015), https://www.facebook.com/permalink.php?story_fbid=834388633266289&id=116317855073374

⁶ K. Schönberger, et al., *Epidemiology of subacute sclerosing panencephalitis (SSPE) in Germany from 2003 to 2009: a risk estimation*, 8 PLOS ONE e68909(2013).

⁷ For criticisms, see: David Gorski, *The Disneyland measles outbreak: “Dr. Bob” Sears says measles isn’t that bad, and an antivaccine activist invokes the Brady Bunch fallacy*, SCIENCE BASED MEDICINE (January 19, 2015), <http://www.sciencebasedmedicine.org/appeal-to-brady-bunch-vaccine-fallacy/>. Dorit Reiss, *Dr. Robert Sears Misleads Parents about Measles and Vaccines*, (January 18, 2015) <http://www.skepticalraptor.com/skepticalraptorblog.php/dr-robert-sears-misleads-parents-measles-vaccines/>.

⁸ Bob Sears, FACEBOOK.COM (March 18, 2014), https://www.facebook.com/permalink.php?story_fbid=684812428223911&id=116317855073374 (emphasis added) (caps lock in original post).

from measles in the U.S. in over 10 years. So, there is ALWAYS the potential for measles. ALWAYS. If you choose not to do the vaccine, then you just have to accept that fact, and **not panic whenever you hear the "M" word.** You've lived with this risk for years, so why panic just because there are **7 cases in the county you live in?** This year there will be more than usual, the way it's looking so far, but it's not a reason to panic. Make your choice—do [sic] vaccine, or don't do the vaccine.

So, when SHOULD someone worry? If an actual direct exposure has occurred from a known case, then you might be at risk. This doesn't mean a case in the county in which you live: it means that you've actually been in the same room with someone who has [had [sic] measles. Or, at the most, maybe the same building. But **transmission almost always requires close proximity (same room).** There have been a handful of cases over the decades in which someone sitting across a stadium has caught it, but that is almost unheard of. **You have to be in the same room, people.** If THAT happens, call me. If not, then just relax and go about your life as usual.

... IF we see more cases, I'll let you know. Actually, just to give you a heads up, we probably WILL see a few more cases. But **virtually all measles outbreaks are limited to 10 to 20 cases in any given county.** So, the chance that any one of your unvaccinated children is going to be a case is very very very very very small.”

Dr. Sears' comments were misleading in several ways. Dr. Sears was making these comments in reference to an outbreak of measles in Orange County, California, in response to an influx of calls from concerned parents asking whether to vaccinate their children with the MMR (Measles, Mumps, Rubella vaccine). At the time of his statement, there were already 21 cases (which later went up to 22, including seven

hospitalizations), three times the “7 cases” he referenced.⁹ In 2014 the United States has seen substantially more cases than any other year since 1994; Dr. Sears’ “more than usual” description doesn’t seem to quite capture the difference.¹⁰ Moreover, while it’s true that there have been no measles deaths in the United States since 2003,¹¹ that is at least partly due to the fact that, thanks to high vaccination rates, measles has been very rare in the United States. In 2000, the CDC declared measles no longer endemic in the United States,¹² though cases continued to be imported from other countries.¹³ Since the rate of death from measles is 1-2 per thousand,¹⁴ it’s not surprising that with only a small numbers of cases, we have not yet seen a fatality. Unfortunately, as the number of cases rises, the United States probably will. Europe had fatalities during its recent measles epidemic.¹⁵

⁹ *Measles*, CAL. DEPT. OF PUBLIC HEALTH, <http://www.cdph.ca.gov/HealthInfo/discond/Pages/Measles.aspx> (last visited _____, 2014).

¹⁰ *Morbidity and Mortality Weekly Report: Measles - United States, January 1-May 23, 2014*, CENTERS FOR DISEASE CONTROL AND PREVENTION (June 6, 2014), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6322a4.htm?s_cid=mm6322a4_w.

¹¹ *Morbidity and Mortality Weekly Report: Epidemiology of Measles - United States, 2001-2003*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 13, 2004), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5331a3.htm>.

¹² *Morbidity and Morality Weekly Report: Measles – United States*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Feb. 15, 2012), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5106a2.htm>.

¹³ *Id.*

¹⁴ CENTERS FOR DISEASE CONTROL AND PREVENTION ET AL., *Measles*, in EPIDEMIOLOGY AND PREVENTION OF VACCINE-PREVENTABLE DISEASES (William Atkinson et al. eds., 12th ed. 2012), available at <http://www.cdc.gov/vaccines/pubs/pinkbook/meas.html>.

¹⁵ *Surveillance Report: European Monthly Measles Monitoring*, EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL, Issue 7 (Jan. 16, 2012), http://ecdc.europa.eu/en/publications/Publications/1201_European_monthly_measles_monitoring_Dec_2011.pdf; see also *Measles Sufferer Gareth Colfer-Williams Died from Pneumonia*, BBC NEWS (July 1, 2013, 2:28 PM), <http://www.bbc.com/news/uk-wales-23135464> (a 25-year-old man in Wales died from measles in 2013); *I Called it - First Measles Death in the Ongoing Outbreak in the Dutch Bible Belt*, JUST THE VAX (Oct. 28, 2013), <http://justthevax.blogspot.co.il/2013/10/i-called-it-first-measles-death-in.html> (a 17-year-old girl in the Netherlands died from measles in 2013).

It's also incorrect to say that you need to be in the same room with someone to contract measles. Measles is extremely contagious, and occupying the same space as someone with it as much as two hours after the person left can lead to infection.¹⁶ When health officials discovered that an infected individual used public transportation in the Bay Area, health authorities warned all public transportation users of possible exposure over a period of three days, noting the virus can linger in the air long after the infected person has departed. According to the health department, this one person who commuted on the train may have exposed thousands of people to the virus.¹⁷

Nor are outbreaks limited to 10-20 cases in a given location. Although many outbreaks are of this magnitude due to high vaccination rates in the United States compared to the pre-vaccine era,¹⁸ there have been some which were significantly larger. Ohio saw over a hundred cases in a concentrated Amish community this year.¹⁹ Wales saw over 1200 cases in 2013. Other outbreaks also were substantial.²⁰ Europe has seen

¹⁶ "Airborne transmission via aerosolized droplet nuclei has been documented in closed areas (e.g., office examination room) for up to 2 hours after a person with measles occupied the area." *Measles*, *supra* note 10.

¹⁷ Ryan Jaslow, *Measles-Infected Student May Have Exposed San Francisco BART Passengers*, CBS NEWS (Feb. 14, 2014, 12:01 PM), <http://www.cbsnews.com/news/measles-scare-in-san-francisco-bay-area-after-infected-student-rides-train/>.

¹⁸ S.S.W. Roush & T.V. Murphy, *Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States*, 298 JAMA 2155 (2007).

¹⁹ *Morbidity and Mortality Weekly Report*, *supra* note 6.

²⁰ Vincent Iannelli, *International Measles Outbreak*, ABOUT.COM (Aug. 6, 2014), <http://pediatrics.about.com/od/measles/a/measles-outbreak.htm>.

tens of thousands of measles cases in recent years, accompanied by deaths, brain damage, as well as other less severe—but still harmful—complications.²¹

By providing his patients with this seemingly reassuring but in fact incorrect information, on two different occasions, both in the context of outbreaks, Dr. Sears was encouraging some parents to leave their currently unvaccinated children at risk of this preventable, potentially dangerous disease. If any of those children contracted the illness and were harmed—or infected another who was harmed—would there be recourse against the doctor who provided the advice?

Similarly, Dr. Jay Gordon wrote a letter to his patients, ending by asserting that “[t]he measles outbreak of 2014 does not pose a risk to your healthy child.”²² While the letter did tell parents that “[i]f you would like the MMR vaccine, please feel free to get it,”²³ the information in it was written to subdue fears and discourage parents from rushing to get the vaccine. Again, if reliance on the advice led to harm, what remedy would be available?

That we have over five hundred cases of measles in the United States in 2014, and 2015 is setting up to be just as bad or worse, is both sad and frustrating. The disease is eminently preventable: we have an extremely effective vaccine. These cases should not be happening. But they are. And they are happening because people choose not to

²¹ *Surveillance Report: European Monthly Measles Monitoring*, EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL, Issue 7 (Jan. 16, 2012), http://ecdc.europa.eu/en/publications/Publications/1201_European_monthly_measles_monitoring_Dec_2011.pdf.

²² Christine Vara, *Say #NoWayDrJay: Don't Bring Measles Back*, SHOT OF PREVENTION (March 31, 2014), <http://shotofprevention.com/2014/03/31/say-nowaydrjay-dont-bring-measles-back/>.

²³ *id.*

vaccinate²⁴—a choice that is mostly based on inaccurate information. Unfortunately, some of that misinformation comes directly from doctors who should know better.

Other preventable diseases can also harm children if their parents refuse to vaccinate against them. Measles is extremely contagious, so it's coming back first. It would be worse if we actually saw diphtheria, polio or HiB reemerging for lack of vaccination—and if vaccination rates drop further, that could happen.²⁵ The diseases are still around. In fact, a Ohio girl was recently diagnosed with diphtheria.²⁶

Doctors—and other health care providers—have an important role in encouraging parents to vaccinate. Patients may look to their doctor as the main source of medical advice, though parents today increasingly also look for other sources of information, including on the Internet.²⁷ If a provider speaks against vaccines, that may make a difference in the parents' decision. So there is a good argument to be made that a doctor should pay for resulting harm if he or she fails to encourage or actively discourages vaccination on schedule., Such practice ignores or rejects a well-known scientific consensus and the body of supporting evidence it is based on, as well as the published

²⁴ “Most of the 288 measles cases reported this year have been in persons who were unvaccinated (200 [69%]) or who had an unknown vaccination status (58 [20%]); 30 (10%) were in persons who were vaccinated. Among the 195 U.S. residents who had measles and were unvaccinated, 165 (85%) declined vaccination because of religious, philosophical, or personal objections, 11 (6%) were missed opportunities for vaccination, and 10 (5%) were too young to receive vaccination (Figure)”. *Morbidity and Mortality Weekly Report*, *supra* note 6.

²⁵ PAUL A. OFFIT, *DEADLY CHOICES: HOW THE ANTI-VACCINE MOVEMENT THREATENS US ALL* 4-5 (Basic Books. 2010).

²⁶ *Ohio Girl Diagnosed with Rare Case of Diphtheria*, WASH. POST, Apr. 29, 2014, <http://www.washingtontimes.com/news/2014/apr/29/ohio-girl-diagnosed-with-rare-case-of-diphtheria/>.

²⁷ Abbey M. Jones et al., *Parents' Source of Vaccine Information and Impact on Vaccine Attitudes, Beliefs, and Nonmedical Exemptions*, 2012 *ADVANCES IN PREVENTIVE MEDICINE* (2012), [http://www.hindawi.com/journals/apm/2012/932741/abs/\(2012\)](http://www.hindawi.com/journals/apm/2012/932741/abs/(2012).).

recommendations of medical professional organizations. After all, with power comes responsibility.

Medical textbooks and an overwhelming scientific consensus support the view that the benefits of modern vaccines far outweigh their rare risks.²⁸ The American Association of Pediatrics supports immunizations.²⁹ So does the World Health Organization.³⁰ The right advice for a pediatrician to give parents is to vaccinate their children on schedule unless a child has a medical contraindication. What happens if a doctor does not give that advice?

This article examines the role of the doctor in providing advice related to vaccines and the circumstances under which a doctor should or should not be liable for advice related to vaccinating. The paper argues that a doctor should advise parents to vaccinate on schedule. If parents refuse in spite of this, and a child contracts a preventable disease, the doctor should not be liable.

²⁸ Most recently, a large scale review, examining adverse events, concluded: “We found evidence that some vaccines are associated with serious AEs; however, these events are extremely rare and must be weighed against the protective benefits that vaccines provide.” Margaret A. Maglione et al., *Safety of Vaccines Used for Routine Immunization in the United States*, 134 PEDIATRICS 1 (July 2014),

²⁹ “Vaccines prevent serious diseases and have helped to lower the rates of these diseases in the U.S. By getting vaccinated, individual children receive protection from these diseases.” Immunization, AM. ACAD. OF PEDIATRICS, <http://www2.aap.org/immunization/families/deciding.html> (last visited ____, 2014). Vaccines also help to protect communities by slowing or stopping disease outbreaks. This is especially important for children who cannot be vaccinated because they are too young, too sick, or do not respond to vaccines. The following pages provide more information that will help give you peace of mind about the decision to immunize your child. *The Childhood Immunization Schedule*, AM. ACAD. OF PEDIATRICS (Oct. 2008), <http://www2.aap.org/immunization/families/Vaccineschedule.pdf>.

³⁰ “Immunization is a proven tool for controlling and eliminating life-threatening infectious diseases and is estimated to avert between 2 and 3 million deaths each year. It is one of the most cost-effective health investments..” *Immunization*, WORLD HEALTH ORGANIZATION, <http://www.who.int/topics/immunization/en/> (last visited ---, 2014).

However, if a doctor did not advise parents to vaccinate, or worse, discouraged them from following the vaccination schedule, a doctor should be liable if a child, or a third party, contracted a preventable disease. The paper explores several theories under which a doctor could be liable in these circumstances.

Part I describes the legal framework governing the provision of medical advice, explaining how duty and breach work in this context. It points out that doctors' duty of care—both to their patients and to third parties—encompasses providing accurate advice that adheres to the standard of care. Medical advice straddles the border between the two types of claims in medical malpractice - negligent medical performance and informed consent - and this section will explain both and address how they apply in the vaccine context. Part II will address potential liability, ranging from least culpable (following the standard of care and recommending vaccines) to most culpable behavior (actively providing incorrect information to parents). Part II.a addresses a scenario where the doctor advised the parents to vaccinate and there is a suit—by the parents or a third party—claiming the doctor did not sufficiently warn the parents of the risks of the decision. It seems clear that there should be no liability in those circumstances, though there is a weak argument about the effect of medical neglect statutes. For completion's sake, the section briefly addresses what should be considered sufficient warning. Part II.b addresses a situation where the doctor did not try to explain to parents the importance of adhering to the schedule, and accepted passively non-vaccination or delayed vaccination (or encouraged the latter), and the child was harmed by contracting the preventable disease, or infected others. In those situations, the article suggests, the doctor should be

liable, even though there are arguments on the other side. Finally, part II.c addresses the most extreme situation, where a doctor actively discourages immunization or provides misinformation that can lead parents to decide not to vaccinate their child. In those cases, liability—and potentially punitive damages—are very appropriate.

I. Legal Framework:

The doctor-patient relationship creates legal duties on the part of the doctor both to the patient and (potentially) to third parties. These duties include a duty to adhere to the professional standard of care and a duty to obtain informed consent.³¹ A doctor may be liable to a patient or a third party for any harms proximately caused when a doctor's conduct—including providing medical advice—fell below the standard of care or if the doctor did not provide the patients with the information needed to make a truly informed decision.

This section will focus on the legal requirements of duty and breach in the context of medical advice related to vaccines. Causation can also be an issue in these kinds of cases. This is less of an issue if the plaintiff is the patient herself—while no vaccine is perfect, since recommended vaccines are 70-99% effective, it should be easy enough for a patient or her parents to demonstrate that vaccination would probably have prevented the patient from contracting the disease. But if the plaintiff is a third party claiming to be infected by the patient, there may be causation problems, though we should not overstate them. For example, in measles outbreaks health authorities have had remarkable success

³¹Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS. 200, 201-203 (1986); Alan Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 54-58 (1977).

in tracking down patients.³² These causation issues have been dealt with in more detail elsewhere, and are not the focus of this article.³³

I. A. Duty of Care

While with some exceptions physicians don't have a duty to accept a patient,³⁴ once a patient has been accepted, the doctor-patient relationship imposes certain duties.³⁵ It's both intuitive and well established that a doctor owes a patient a duty of care.³⁶ The basis of that duty is the special relationship between patient and doctor, a relationship of dependence that requires the patient, to some degree, to place herself in the doctor's hands and trust that doctor.³⁷

Not quite as obvious, in some circumstances courts have found that doctors owe third parties duties of care.³⁸ The most extreme version was probably *Tarasoff v. Regents of University of California*,³⁹ in which California's Supreme Court created a duty on the part of a therapist to warn victims of a patient if that patient poses a risk to them. The

³² See, e.g., David E. Sugerman et al., *Measles Outbreak in a Highly Vaccinated Population, San Diego, 2008: Role of the Intentionally Undervaccinated*, 125 PEDIATRICS 747 (2010).

³³ Arthur L. Caplan et al., *Free to Choose But Liable for the Consequences: Should Non-Vaccinators be Penalized for the Harm They Do?*, 40 J.L. MED. & ETHICS 606 (2012); Dorit R. Reiss, *Compensating the Victims of Failure to Vaccinate: What are the Options?*, 23 CORNELL J.L. & PUB. POL'Y 595 (2014).

³⁴ Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 590-591 (2008). See *id.* at 591-94 for the relatively broad exceptions.

³⁵ *Id.*

³⁶ Dennis Vidrine, *The Medical Malpractice Action in Louisiana*, 33 LA. L. REV. 420, 421-423 (1973).

³⁷ Mehlman, Maxwell J., *The Patient-Physician Relationship in an Era of Scarce Resources: Is there a Duty to Treat*, 25 CONN. L. REV. 349, 352-353 (1992-1993).

³⁸ For a general discussion of this see Restatement (Third) of Torts, §41 comment h.

³⁹ *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal.3d 425 (1976).

extent of the duty is somewhat unclear,⁴⁰ but the decision was a broad expansion of duties to third parties, and has since been applied beyond the therapist context. Doctors have been held to have a duty to warn in several contexts.⁴¹ For example, doctors were found to have a duty to warn relatives that they may be at risk from a genetically transmissible condition (like developing a form of cancer).⁴²

Even before *Tarasoff*, courts found a duty to warn third parties that may be exposed to contagious diseases a patient has.⁴³ Going further, in one case a doctor was found to have a duty to take steps to protect a minor child from a parent's infectious disease even when the doctor did not actually know of the infectious disease because of negligence in discovering it.⁴⁴

These cases suggest that in the context of infectious diseases, some duty to third parties has long been accepted. While framed in the context of a duty to warn, the cases also extend to misdiagnosis, suggesting that they also include other potential duties. Actively advising patients not to vaccinate, or encouraging non-vaccination, has extremely foreseeable and direct implications for third parties; the patient, at higher risk

⁴⁰ Robert N. Cohen, *Tarasoff v. Regents of the University of California: The Duty to Warn: Common Law & Statutory Problems for California Psychotherapists*, 14 CAL. W. L. REV. 153 (1978-1979); Robert B. Kaplan, *Tarasoff v. Regents of the University of California: Psychotherapists, Policemen and the Duty to Warn-An Unreasonable Extension of the Common Law*, 6 GOLDEN GATE U. L. REV. 229 (1975-1976).

⁴¹ See Jeffrey W. Burnett, *A Physician's Duty to Warn a Patient's Relatives of a Patient's Genetically Inheritable Disease*, 36 HOUS. L. REV. 559, 563-569 (1999).

⁴² Mary L. Kovalesky, *To Disclose or Not to Disclose: Determining the Scope and Exercise of a Physician's Duty to Warn Third Parties of Genetically Transmissible Conditions*, 76 U. CIN. L. REV. 1019, 1020-21 (2007-2008).

⁴³ *Id.* at 1023-1025; see also *Jones v. Stanko*, 118 Ohio St. 147 (1928).

⁴⁴ *ofmann v. Blackmon*, 241 So. 2d 752 (Fla. Dist. Ct. App. 4th Dist. 1970).

of contracting the diseases,⁴⁵ is therefore significantly more likely to infect others. Since liability will be limited by application of the requirement of proximate cause or scope of liability, it is appropriate to extend duty to third parties in this situation.

I. B. Medical Malpractice:

Two kinds of claims fall under the heading of medical malpractice. Physicians can be sued for negligent medical performance because their actions fell below the standard of care, or they can be sued for not obtaining their patients' informed consent even if their performance is not substandard.

Problematic advice can fall under either of those claims, depending on the circumstances, or can sometimes give rise to both claims.

II.B.i Negligent Medical Performance

Under the current standard of care for medical malpractice, a physician must act with the degree of "...Skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."⁴⁶ This is generally interpreted to require the physician to follow the custom in the profession, determined by expert testimony and sources like medical literature, professional organizations' positions, and so forth.⁴⁷ The standard to which a doctor is held can be a local, state or national standard, but increasingly jurisdictions have been holding board certified

⁴⁵ See, e.g., Jason M. Glanz et al., *Parental Refusal of Pertussis Vaccination Is Associated with an Increased Risk of Pertussis Infection in Children*, 123 PEDIATRICS 1446 (June 2009); Daniel R. Feikin et al., *Individual and Community Risk of Measles and Pertussis Associated with Personal Exemptions to Immunizations*, 284 JAMA 3145, no. 24 (Dec. 27, 2000).

⁴⁶ Restatement (Second) Torts §299A.

⁴⁷ *Birchfield v. Texarkana Memorial Hospital*, 747 S.W.2d 361 (Tex 1987) (apparently considering AAP guidelines as standard by which hospital should have treated pediatric patient);

specialists to a national standard.⁴⁸ Pediatricians are board certified specialists, and many jurisdictions will hold them to the national standard. The rationale is that specialists are subjected to national exams to become certified, and work with national associations.

Some jurisdictions also subject doctors more generally to a national standard, though not all.⁴⁹ The concern among jurisdictions that still adhere to the local standard is that doctors in some local areas—especially more rural areas—will be unable to meet the national standard and find themselves facing heavy liability that will deter them from practicing, thereby reducing the medical services available to those in such areas.⁵⁰ Family physicians may, therefore, be subject to a different standard. One possible source of such a standard can be found in a state’s school immunization requirements, which may be seen to set a minimum requirement.⁵¹

How does this apply to vaccination?

The pediatric standard of care includes the provision of routine childhood immunizations according to the recommended schedule. The American Academy of Pediatrics (AAP) is a professional membership organization of primary care pediatricians and pediatric specialists.⁵² The AAP issues policy statements, clinical practice

⁴⁸ See, e.g., *Jordan v. Bogner*, 844 P.2d 664 (Colo. 1993).

⁴⁹ See, e.g., *Hall v. Hilbrun*, 466 So. 2d 856 (Miss. 1985); *Vergara v. Doan*, 593 N.E.2d 185, 187 (Ind. 1992); but see M.C.L.A. § 600.2912a(1)(a); Committee on Medical Liability, *Guidelines for Expert Witness Testimony in Medical Malpractice Litigation*, 109 PEDIATRICS 974, 975 (2002).

⁵⁰ John Kimbrough Johnson, Jr., *An Evaluation in the Medical Standard of Care*, 23 VAND. L. REV. 729, 731-32 (1970).

⁵¹ Steve P. Calandrillo, *Vanishing Vaccinations: Why Are So Many Americans Opting Out of Vaccinating Their Children*, 37 U. MICH. J.L. REFORM 353 (2004); Walter A. Orenstein & Alan R. Hinman, *The Immunization System in the United States - The Role of School Immunization Laws*, 17 VACCINE 19, supplement 3 (1999).

⁵² *AAP Facts*, AM. ACAD. OF PEDIATRICS, <http://www.aap.org/en-us/about-the-aap/aap-facts/Pages/AAP-Facts.aspx> (last visited ----, 2014).

guidelines⁵³ and technical reports that form the basis of pediatric preventive care.⁵⁴ As part of its commitment to preventive healthcare, the AAP encourages the use of childhood vaccinations.⁵⁵ The strength of its support for immunization can be seen by the fact that their main website opens with a discussion of “AAP, Immunization & You”, saying:

One very important step in ensuring the health of any child is to make sure he or she receives immunizations at the correct time. Whether it's a childhood MMR vaccine or an adolescent pertussis booster, these simple procedures can save lives—and AAP is here to answer any questions you may have about childhood immunization.⁵⁶

The AAP has specifically adopted the recommendations of the National Vaccine Advisory Committee (NVAC) Standards for Child and Adolescent Immunization Practices as representing “the most desirable immunization practices, which pediatricians

⁵⁰ Kimberley J. Todd, *Snyder v. American Association of Blood Banks: Expansion of Trade Association Liability – Does it Reach Medical Societies?*, 29 U. Tol. L. Rev. 149 (Fall 1997) (discussing cases in which different medical professional organizations, including the AAP formed the standard of care).

⁵⁴ *AAP Facts*, *supra* note 48

⁵⁵ *NVAC Standards 11 & 13*, AM. ACAD. OF PEDIATRICS, <http://www2.aap.org/immunization/pediatricians/NVACStandards/NVACStandard11and%2013.pdf> (last visited ----, 2014).

⁵⁶ *Immunization*, AM. ACAD. OF PEDIATRICS, <http://www2.aap.org/immunization/> (last visited ----, 2014).

should strive to achieve.”⁵⁷ Along with the AAP, numerous other healthcare professional organizations have adopted the NVAC standards for immunization.⁵⁸

Vaccines are also recommended by other professional bodies in the health field.⁵⁹ The Merck Manual, commonly used as a medical reference text, supports vaccines.⁶⁰ Other textbooks also strongly support vaccination.⁶¹ There is an overwhelming body of literature supporting the importance and benefits of childhood vaccination.⁶² The CDC’s recommendations regarding vaccination have also been held out as providing the standard of care.⁶³

The standard of care is also set by the common custom of other pediatricians. Although there are no definitive statistics on the percentage of pediatricians and family

⁵⁷ *NVAC Standards 11 & 13*, *supra* note 51; *see also*, NVAC, *Standards for Child and Adolescent Immunization Practices*, 2003 and private providers, developed a set of standards as to what constitutes the most essential and desirable immunization policies and practices.

⁵⁸ Including, Advisory Committee on Immunization Practices, American Academy of Family Physicians, American College of Emergency Physicians, American College of Osteopathic Pediatricians, American College of Preventative Medicine, American Medical Association, American Nurses Association, American Public Health Association, and the Pediatric Infectious Disease Society among many others. <http://pediatrics.aappublications.org/content/112/4/958/T2.expansion.html> Table 1

⁵⁹ “There are a number of vaccines that are unanimously recommended by key health organizations, including the Centers for Disease Control and Prevention, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians and the American Medical Association, among others.” *Recommended Vaccinations*, N.Y. DEPT. OF HEALTH, https://www.health.ny.gov/prevention/immunization/recommended_vaccinations.htm (last visited ---, 2014).

⁶⁰ *Effectiveness and Safety of Childhood Immunization*, MERCK MANUALS, http://www.merckmanuals.com/professional/pediatrics/childhood_vaccination/effectiveness_and_safety_of_childhood_vaccination.html (last visited ----, 2014).

⁶¹ ROBERT M. KLIEGMAN ET AL., NELSON TEXTBOOK OF PEDIATRICS 947-48, 1077-78 (Elsevier 19th ed. 2011); Anne Schuchat & Lisa A. Jackson, *Immunization Principles and Vaccine Use*, in HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, (Dan L. Longo et al. eds., 2012); WILLIAM HAY ET AL., *Immunization*, in CURRENT DIAGNOSIS AND TREATMENT PEDIATRICS (21st ed. 2012).

Paul A. Offit & Frank Destefano, *Vaccine Safety*, in VACCINES: EXPERT CONSULT (Stanley A. Plotkin et al. eds., 2012); Margaret A. Maglione et al., *Safety of Vaccines Used for Routine Immunization of US Children: A Systematic Review*, 134 PEDIATRICS, no. 2 (July 1, 2014).

⁶² *Matthews v. Aganad*, 914 N.E.2d 1233 (Ill. 2009).

⁶³ *Id.*

practitioners that follow the recommended vaccine schedule and NVAC guidelines in their practices, we do know that roughly 90% of pediatric patients are vaccinated on schedule.⁶⁴ This would indicate that the customary practice for the majority of pediatric care providers is to vaccinate according to the NVAC standards. This is further supported by some of the explanations provided by those pediatric practices which—a growing trend—refuse to treat patients who refuse to be vaccinated.⁶⁵ These physicians often refuse care to unvaccinated patients because it places the physician in the uncomfortable, and perhaps unsustainable, position of being asked to treat patients who are operating against appropriate medical advice and thus receiving sub-standard care.⁶⁶

One potential counter argument is that not vaccinating or vaccinating on a delayed schedule is, nonetheless, the custom of a respectable minority, and hence, a legitimate alternative to vaccinating.⁶⁷ There are a few problems with that approach. No professional association endorses not vaccinating, or vaccinating on a delayed schedule. Professional textbooks oppose it. Expert bodies have concluded, for each vaccine on the schedule, that its benefits outweigh its risks and that it's cost effective to use it.⁶⁸ There is

⁶⁴ Preeti Malani, *Vaccination Rates for US Children Remain Generally High, But Measles Outbreaks Underscore Shortfalls in Some Regions*, JAMA (Sept. 16, 2013), <http://newsatjama.jama.com/2013/09/16/vaccination-rates-for-us-children-remain-generally-high-but-measles-outbreaks-underscore-shortfalls-in-some-regions/>.

⁶⁵ Shirley S. Wang, *More Doctors 'Fire' Vaccine Refusers*, WALL ST. J. (Feb. 15, 2012), <http://online.wsj.com/news/articles/SB10001424052970203315804577209230884246636>.

⁶⁶ Wolfe Nadoolman, *Vaccine Refusal and Ethical Issues*, THE EMPATHIC PEDIATRICIAN (July 18, 2010), <http://drwolfe.blogspot.co.il/2010/07/vaccine-refusal-and-ethical-issues.html>.

⁶⁷ *Pesek v. University Neurologists Ass'n*, 721 N.E.2d 1011 (Ohio 2000).

⁶⁸ Margaret A. Maglione, et al., *Safety of Vaccines Used for Routine Immunization of US Children: A Systematic Review*, doi: 10.1542/peds.2014-1079 PEDIATRICS (2014).

no good scientific support for the claim that the risks outweigh the benefits for any of them.

Delaying is also not supported. The evidence is that the current schedule is safe.⁶⁹ There is also no scientific support to the claim that delaying vaccines is beneficial, and there are studies that go the other way.⁷⁰

With no basis in the literature, and no empirical support, there is nothing that makes not vaccinating on schedule a respectable alternative.⁷¹

By any possible standard, vaccinating is the standard of care.

I.B.ii Informed Consent:

The other claim that can be brought against a doctor is a claim of informed consent. The ethical justification for the requirement of informed consent is the patient's autonomy.⁷² The law moved away from a battery-based claim—a claim that allowed a patient to recover only if there was no consent to the treatment⁷³—to a negligence-based claim that allowed patients to recover when consent was flawed.⁷⁴ The heart of informed

⁶⁹ As highlighted by a recent Institute of Medicine Report: *The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies*. (2012).

⁷⁰ Kristen A. Feemster & Paul A. Offit, *Delaying Vaccination Is Not a Safer Choice*, 167 *JAMA PEDIATRICS* 1097(2013). See also: Fernando A. Guerra, *Delays in Immunization Have Potentially Serious Health Consequences*, 9 *PEDIATRIC DRUGS* (2007).

⁷¹ Dr. Bob Sears, as mentioned, has a lay-directed book in which he suggests an alternative schedule. But Dr. Sears' has no vaccine-related peer-reviewed publications. His alternative schedule is made up, with no scientific support, and is not acknowledged or accepted by any professional body. It was criticized by those with actual expertise related to vaccines: Paul A. Offit & Charlotte A. Moser, *The Problem With Dr Bob's Alternative Vaccine Schedule*, 123 *PEDIATRICS* 164 (2009). It seems problematic to treat a popular book with no professional basis as a source of a respectable custom. Especially with no evidence that some noticeable minority of physicians recommend it.

⁷² Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 *AM. J.L. & MED.* 429, 435-37.

⁷³ *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

⁷⁴ King & Moulton, *supra* note 64, pp. 438-40.

consent is a requirement that patients be informed of the risks, benefits and alternatives to treatment before making a health-related decision.⁷⁵ What that actually entails can vary.

Two standards are used to assess whether the information provided by the doctor meets the standard for informed consent. Under the physician-based standard, a doctor needs to inform a patient of the risks of a treatment “to the same degree that a ‘reasonably prudent practitioner in the same field of practice or specialty in [that state]’ would.”⁷⁶ Under the patient-based standard, a physician must disclose material risks—risks that a reasonable person in the patient’s position would want to know.⁷⁷

To win an informed consent claim a patient must show that a doctor breached the relevant standard, and that the breach proximately caused the patient’s harm: i.e. that knowing the information would have led the patient to a different decision.⁷⁸

In the vaccine context, it’s important that a doctor provide patients information about vaccines, and also about the risks of the choice not to vaccinate. If not warning of a genetic or infectious disease can lead to liability, so can failure to warn of the hazards of refusing to take the standard precaution of vaccination to prevent an infectious disease.

Medical advice related to vaccinating straddles the line between medical performance—vaccinating is part of the standard of care—and informed consent, a doctor must inform a patient of the benefits and (very slight) risks that come with vaccination

⁷⁵ Id, at p. 439.

⁷⁶ Id, at p. 441

⁷⁷ Id, at p. 445

⁷⁸ Id, at p. 441 and 445

and the considerable risks encountered in refusal of vaccination. By not properly advising, a doctor violates both at the same time: she falls below the standard of care, performs negligently, and she denies her patients their right to make an informed choice about whether or not to vaccinate.

II. Advising about Vaccines: Liability Pitfalls

II.A. Advising to Vaccinate:

A patient comes in, and a doctor suggests the child should get vaccines. The parent refuses. The child contracts a vaccine-preventable disease and either suffers harm herself or infects another. Should the doctor be liable, either to the child or to a third party harmed? Would it matter if the child came in between well visits for specific reasons, and the vaccine issue was not raised then?

Generally speaking, if a doctor advised a parent to vaccinate, a doctor should not be liable for the consequences if the parent decides not to vaccinate. This is true even if there are interim visits for specific reasons that are missed opportunities to discuss vaccines.

For good or bad, patient autonomy is a major tenet of our system.⁷⁹ A doctor cannot impose treatment on an adult in sound mind, up to and including life saving treatment.⁸⁰ The situation is somewhat different for children: a parent can be required to act to save a child's life, or even for less dramatic reasons.⁸¹ A parent may even be required to provide

⁷⁹ id.

⁸⁰ id.

⁸¹ ROBERT H. MNOOKIN & D. KELLY WEISBERG, CHILD, FAMILY AND STATE: PROBLEMS AND MATERIALS ON CHILDREN AND THE LAW ch. 4 (7th ed. 2014); ALISON DUNDES RENTELN, THE CULTURAL DEFENSE 67-70 (2004).

medical treatment short of saving a child's life.⁸² In the context of vaccination, however, the cases where parents have been required to vaccinate children are very few, and limited to situations of outbreaks. During a 1991 measles outbreak in Pennsylvania, a judge ordered forced vaccination of children whose parents were members of a religious community opposed to vaccination after several children died of measles.⁸³ In *Christine M.*, a father was found in neglect for not vaccinating his young child during a measles outbreak. But even there, the court forbore to order vaccination, since by the time the case was decided the outbreak had ended.⁸⁴

While all states have school immunization requirements, all states also allow parents some kind of alternative to vaccination. Most states offer exemptions, or allow children to be homeschooled if unvaccinated.⁸⁵ The few states that apply school immunization requirements to homeschooled children have non-medical exemptions available.⁸⁶

The picture that emerges is that, in the United States in most circumstances parents can choose not to have their children vaccinated. Patient autonomy means that parents do not have to take a doctor's advice to vaccinate. With that freedom should come

⁸² Renteln, *id.*

⁸³ Paul A. Offit, *The Philadelphia Measles Outbreak*, AM. ACAD. OF PEDIATRICS, <http://www.aapnj.org/uploadfiles/documents/2014/AC/phila%20measles%20II.pdf>.

⁸⁴ *In re Christine M.*, 595 N.Y.S.2d 606, 616 (Fam. Ct. 1992).

⁸⁵ Nina R. Blank et al., *Exempting Schoolchildren From Immunizations: States With Few Barriers Had Highest Rates Of Nonmedical Exemptions*, 32 HEALTH AFFAIRS 1280 (2013); Calandrillo, U. MICH. J.L. REFORM, (2004) ; Alicia Novak, *The Religious and Philosophical Exemption to State-Compelled Vaccination: Constitutional and Other Challenges*, 7 U. PA. J. CONST. L. 1101 (2005).

⁸⁶ Dorit R. Reiss, *Rights of the Unvaccinated Child: The Role of School Immunization Requirements*, SHOT OF PREVENTION (March 20, 2014), <http://shotofprevention.com/2014/03/20/rights-of-the-unvaccinated-child-the-role-of-school-immunization-requirements/>.

responsibility: if the parent rejected the doctor's advice to vaccinate and their child was harmed by that, they should be the one to bear the cost, not the doctor who followed the standard of care and advised them appropriately.⁸⁷

One potential counter to this claim is that doctors are, in all states, mandatory reporters of child abuse.⁸⁸ While not all states impose tort liability for violating the duty to report, at least some do, via the statute or via court decisions.⁸⁹ A case can be made that not vaccinating is at least medical neglect.⁹⁰ While serious adverse events can happen, they are extremely rare.⁹¹ Unvaccinated children are at substantially higher risk of preventable diseases than vaccinated children.⁹² In other words, they are much more at risk, and arguably, not vaccinating them, choosing the greater risk for them,⁹³ is inappropriate. Should doctors whose patients refuse to vaccinate be liable if they did not

⁸⁷ "A patient has a duty to cooperate with his or her physician by following the physician's instructions regarding treatment and tests, and a failure on the part of the patient in this respect which contributes to injury claimed to have arisen from the physician's negligence or malpractice will bar recovery therefore. Thus, a physician or surgeon who is prevented from curing an ailment by the refusal of the patient to submit to proper treatment cannot be held liable for resulting damages." Paul Coltoff et al., *Effect of Patient's Negligence*, 70 C.J.S. *Physicians and Surgeons* § 94 (2014).

⁸⁸ Mnookin and Weisberg, *Supra* Note ##, pp. 228.

⁸⁹ *Id.*, pp. 224-228.

⁹⁰ For an example of medical neglect see, e.g., e.g. *Faunteroy v. U. S.*, 413 A.2d 1294 (D.C. 1980)).

⁹¹ Maglione et al, *supra* note 23.

⁹² Daniel R. Feikin et al., Individual and Community Risks of Measles and Pertussis Associated With Personal Exemptions to Immunization, 284 JAMA 3145 (2000). Jason M. Glanz, et al., Parental Refusal of Pertussis Vaccination Is Associated With an Increased Risk of Pertussis Infection in Children, 123 PEDIATRICS 1446(2009).

⁹³ *Comparison of Effects of Diseases and Vaccines- Canadian Immunization Guide*, PUBLIC HEALTH AGENCY OF CANADA, <http://www.phac-aspc.gc.ca/publicat/cig-gci/cedv-cemv-tab-eng.php> (Canada); *Diseases & the Vaccines that Prevent Them*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/vaccines/vpd-vac/fact-sheet-parents.html> (United States).

report the non-vaccinating parent as at least suspect of child neglect, and the child was harmed by non-vaccinating?

We see a number of problems with this view, both on legal and policy grounds, and believe it is inappropriate. First, it is not clear this is the kind of neglect that should be reported. There is substantial debate on the definition of abuse and neglect, with some advocates concerned about extending it too broadly.⁹⁴ Criminal cases of medical neglect addressed behavior that was pretty extreme: starving a child or child in need of immediate intervention.⁹⁵ Not vaccinating a healthy child can kill, and can arguably be medical neglect, but it's an extension even from the parent's point of view – and the doctor is once removed.

Further, legally, the existence of exemptions can also go against this. Most states have non-medical exemptions.⁹⁶ While exemptions are adopted in a different context, they can be read as at the very least making non-vaccination not medical neglect when the parents has a legal exemption. In that case, doctors have no duty to report.

On policy grounds, continuing with the theme of exemption, it's neither fair nor desirable to expect doctors to decide when a parent is legally exempt. Doctors are not trained in law, and it's not their job to apply exemption law.

⁹⁴ Diana J. English, *The Extent and Consequences of Child Maltreatment* 8 THE FUTURE OF CHILDREN 40-42 (Spring 1998).

⁹⁵ e.g. *State v. Jones*, 778 So. 2d 1131 (La. 2001), *People v. Pierson*, 176 N.Y. 201 (1903), *Faunteroy v. U. S.*, 413 A.2d 1294 (D.C. 1980), *State v. Crawford*, 188 Neb. 378 (1972)).

⁹⁶ Hope Lu, *Giving Families their Best Shot: A Law-Medicine Perspective on the Right to Religious Exmptions from Mandatory Vaccination*, 63 CASE WESTERN RESERVE LAW REVIEW 869(2013). Mississippi and West Virginia are the only exceptions.

Making doctors liable for not reporting in these situations can also deter non-vaccinating parents from seeking medical care. This has two costs: it can deprive doctors from the opportunity to try to change the parents' mind, and it can deny the child – already at risk – medical care. Given the burden on Child Protective Service, it's also unlikely that there will be consequences from reporting – so imposing liability for not reporting, when reporting wouldn't have helped, seems especially unfair (and causation will be an issue. Finally, it seems that imposing liability for not reporting in this situation is penalizing the doctor for the parents' choice.

For all these reasons, we believe that it's inappropriate to hold the doctor liable for not reporting parents who do not vaccinate against the doctor's advice.

Should a doctor be liable when the harm is to a third party who did not make the choice to assume the risk of refusing vaccination. However, the strong protection afforded by most states to the parent's authority to make that decision supports, in our view, a similar result: while it is appropriate for a third party to be able to sue the non-vaccinating parent,⁹⁷ they should not be able to go beyond the parent and sue the doctor.

This could mean a third party is left with no remedy if the non-vaccinating parents are unable to pay. But it is unfair to hold a doctor liable for a problematic parental decision over which the doctor has little control.

⁹⁷ Arthur Caplan et al., *Free to Choose But Liable for the Consequences: Should Non-Vaccinators be Penalized for the Harm They Do?* 40 J.L. MED. & ETHICS, 606, 606 (2012); Douglas S. Diekema, *Choices Should Have Consequences: Failure to Vaccinate, Harm to Others, and Civil Liability*, 107 MICH. L. REV. FIRST IMPRESSIONS 90 (2009); Dorit Reiss, *Compensating the Victims of Failure to Vaccinate: What are the Options?* 23 CORNELL J.L. & PUB. POL'Y, 595, 597 (2014); but see Daniel B. Rubin & Sophie Kasimow, *The Problem of Vaccination Non-Compliance: Public Health Goals and the Limitations of Tort Law*, 107 MICH L. REV. FIRST IMPRESSIONS 114 (2009).

Furthermore, the doctor should not be liable for not repeatedly pushing the issue of vaccination every time the child came in sick: while it is certainly appropriate for a doctor to raise the issue in those circumstances, and even a positive thing to be encouraged, the fact that a doctor faced with a suffering child focused on the problem at hand rather than on the previous lack of vaccination is reasonable. Medical liability can be a serious burden. If the parent decided to deny the child the vaccine, the doctor's focus on the problem at hand during a subsequent visit is not enough to justify shifting that burden from the deciding parent to the advising doctor. The buck should stop with the parent.

As a practical matter, it might be a good idea for doctors to have written evidence that they did, in fact, advise the parents to vaccinate. The AAP suggests a model form to have non-vaccinating parents sign⁹⁸ titled "Refusal to Vaccinate"; but because that form includes language saying that the parent acknowledges the risks of non-vaccinating,⁹⁹ anti-vaccine sites warn their members against signing that form, suggesting it can be a basis for action by Child Protective Services (CPS) or even criminal sanctions against the parent if a child is harmed by the decision.¹⁰⁰ One way to handle this is to create a simpler form saying that the parent received information or to give all parents, vaccinating or not, the Vaccine Information Sheets that have to be provided to

⁹⁸ Dennis Murray & Ed Rothstein, *Documenting Parental Refusal to Have Their Children Vaccinated*, AM. ACAD. OF PEDIATRICS, <http://www2.aap.org/immunization/pediatricians/pdf/refusaltovaccinate.pdf>.

⁹⁹ For example: "I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others with whom my child might come into contact." *id.*

¹⁰⁰ *Vaccine Refusal Form*, EDUCATE4THEINJURED, <http://www.educate4theinjured.org/#!vaccine-refusal-form/cno1> (last visited ---, 2014); *Do Not Sign AAP Or Other Self-Incriminating Vaccine Refusal Forms*, VACCINE LIBERATION, <http://www.vaclib.org/legal/donotsign.htm> (last visited ---, 2014).

vaccinating parents, and to obtain the same acknowledgement from everyone. If the parent refuses to sign even that, the doctor can make a note in real time stating that the information was offered and refused.

II.B. Tacit Omissions/Implicit Support:

A patient comes in, and being asked about vaccines says that she does not vaccinate, and the doctor says nothing, leaving it at that. No attempt to convince the patient to vaccinate, no discussion of the risks of the course of action. Alternatively, a patient comes in with an infant of two months, and the doctor says nothing about vaccines, not even mentioning the subject. If the child contracts a preventable disease and is harmed herself, or infects another who is harmed, should the doctor be liable?

This is an intermediate case, where the doctor's behavior is not as culpable as actively deterring a patient from vaccinating but may not be up to the standard: again, the standard is that the doctor should vaccinate the child according to schedule, so the doctor should advise accordingly. On one hand, there are the realities of modern medical practice: doctors have limited time with patients, and fighting a patient who comes in with a strong opinion against vaccines may not be the best use of that time. Research suggests that some patients opposed to vaccines are unreachable,¹⁰¹ and if a doctor judges that to be the case, maybe time would better be used taking care of the child's other needs. It can no doubt be wearing to have the discussion with parent after parent, in the

¹⁰¹E. Allison Hagood & Stacy Mintzer Herlihy, *Addressing Heterogeneous Parental Concerns About Vaccination with a Multiple-Source Model: A Parent and Educator Perspective*, 9 HUMAN VACCINES & IMMUNOTHERAPEUTICS (2013), http://www.landesbioscience.com/journals/vaccines/article/24888/?show_full_text=true.

middle of an intensely busy day, to respond to the same misconceptions, to dispel distrust and conspiracy theories, to bang your head against the wall of anti-vaccine claims.

On the other hand, it is a doctor's responsibility to provide the best care available. Lack of time is not a good justification to neglect providing advice that is important to a child's health. And while understandable, weariness is no more a justification here than it would be justification for a driver not paying attention to the road or for a doctor making other mistakes (for example, forgetting a sponge in a person's body). At the least, a parent needs to be made aware of the risks of not vaccinating. A doctor may not be able to force a parent to engage in a discussion, and is certainly not able to force a parent to listen, but a doctor can at least provide the vaccine information sheet. A parent choosing not to vaccinate is choosing a dramatically larger risk over a much, much smaller one.¹⁰²

A doctor has affirmative duties to a patient, and not actively warning a parent that they are choosing against the risk calculus is failing in those duties. Nor is it an unreasonably high burden to expect a doctor to at least make an effort—at least by providing appropriate sources of information—to inform patients of the vaccine schedule and the risks of deviating from it. After all, this is the professionally supported schedule, and the standard supported by the AAP and the CDC, and what respected medical textbooks instruct. It is a physician's professional duty to know it—and it's their professional duty to know it in order to best advise their patients about the safer course of action.

¹⁰² For comparisons of the risks of diseases to the risks of vaccines see here for Canada: <http://www.phac-aspc.gc.ca/publicat/cig-gci/cedv-cemv-tab-eng.php>; here for the United States: <http://www.cdc.gov/vaccines/vpd-vac/fact-sheet-parents.html>. See also Calandrillo, *Vanishing Vaccinations: Why Are So Many Americans Opting Out of Vaccinating Their Children* at 391-93.

Non-vaccinating parents can—and according to the Internet, some indeed do—interpret a doctor’s attempt to convince them to vaccinate as coercive, or as “bullying.”¹⁰³ A parent may not appreciate a doctor’s effort to inform and convince, and this can have a detrimental effect on the relationship, and hence on the treatment. But a parent’s reluctance to receive accurate information is a problematic reason not to provide it. In the pediatrician relationship, especially, the patient is not the parent: it’s the child. Not providing the parent information about the risks to the child’s health from a course of action is failing in the duty to that child. A parent whose child later suffered because of a preventable disease would have a legitimate grievance if they had not been informed of the real risks. A third party would also have a grievance, if a doctor did not inform a parent that leaving their child unvaccinated can lead to others being infected.

Another wrinkle is that anti-vaccine activists’ desire to avoid pressure from doctors to vaccinate and the choice of some doctors to “fire” non-vaccinating parents has led, among other things, to the development of lists of anti-vaccine friendly doctors, lists that are now disseminated across anti-vaccine sites.¹⁰⁴ Doctors are not asked before their names are put on those lists, and conversations suggest some of them are surprised to find out that they are on such a list, but they are. If a doctor is willing to let slide the decision

¹⁰³ Cathy Jameson, *Things to Know or Do When You’re Up Against a Vaccine Bully*, AGE OF AUTISM (Oct. 20, 2013, 5:45 AM), <http://www.ageofautism.com/2013/10/things-to-know-or-do-when-youre-up-against-a-vaccine-bully.html>; *Bullying, Rude and Discriminatory Doctors Who Forget Vaccines Are a Choice*, VACCINE AWARENESS NETWORK (Feb. 27, 2014), <http://www.vaccineriskawareness.com/Bullying-Rude-and-Discriminatory-Doctors-who-Forget-Vaccines-are-a-CHOICE>.

¹⁰⁴ *New List of Vaccine Friendly Doctors State by State*, BABYCENTER.COM (May 21, 2014), http://community.babycenter.com/post/a30859003/new_list_of_vaccine_friendly_doctors_state_by_state; *Archived List of Doctors Reported to Accept Patients Who Do Not Vaccinate*, VACCINATION LIBERATION, <http://vaclib.org/basic/health/novaxdoctors.htm> (last visited ----, 2014); *Find a Vaccine-Friendly Doctor Near You*, ASKDRSEARS.COM, <http://www.askdrsears.com/topics/health-concerns/vaccines/find-vaccine-friendly-doctor-near-you> (last visited ----, 2014).

not to vaccinate, not to attempt to convince such parents, they may become a magnet for non-vaccinating parents. That means that such doctors can have a higher concentration of such parents in their waiting room, making such a waiting room a potential locus for outbreaks (since a higher concentration of unvaccinated children means a larger population susceptible to infection by a sick child coming in). This is not a theoretical concern: the 2008 San Diego measles outbreak started when an unvaccinated patient traveling abroad brought back measles, among other places, to the waiting room of such a non-vaccinating-friendly pediatrician.¹⁰⁵ This creates a potential risk for other patients in the waiting room. It may also create a duty on the part of a doctor with a high number of patients who are not vaccinated, or who are selectively vaccinated, or who have delayed vaccination, to warn other patients of that fact—so they will be aware of the risk. If a newborn contracts a preventable disease because a doctor tacitly encouraged non-vaccinating parents to seek her clinic the parents may, again, have a reasonable grievance against the doctor. This may, however, require a separate discussion, because this is an affirmative duty that is much more extensive than the usual affirmative duties placed on a doctor.

In short, anything less than actually advising patients—at every well visit—to vaccinate creates a risk to the child-patient and to others that child might infect. If that risk materializes, a doctor may well be found liable—and indeed, should be.

¹⁰⁵ Sugerman, *supra* note 28 For the identity of the doctor, see Seth Mnookin, *Dr. Bob Sears: Bald-Faced Liar, Devious Dissembler, or Both?*, PLOS.ORG (March 26, 2012), <http://blogs.plos.org/thepanicvirus/2012/03/26/bob-sears-bald-faced-liar-deviuous-dissembler-or-both/>.

II.c. Applying the principles to doctors who advise against the recommended vaccine schedule

Applying the underlying principles of medical malpractice to physicians who advise against vaccination leads to two legitimate theories of liability against these healthcare providers should their advice cause injury to a patient or to a third party.

1. Negligent medical performance

As we have seen, a physician is liable to a patient for injuries caused when the physician's professional actions fall below, or outside of, the established standard of care.¹⁰⁶ How does this apply to a situation where the physician advises delaying or avoiding certain vaccinations with no valid medical reason? (An example of a valid medical reason—probably the most common one—is a case where there is a contraindication which makes it advisable to delay or permanently avoid using specific vaccines.)¹⁰⁷

Several of the National Vaccine Advisory Committee (NVAC) standards, endorsed by the AAP, are particularly relevant when considering the potential liability of pediatricians and other physicians that advise their patients to either avoid or delay routine childhood immunizations. Consider, for example, the situation where a pediatrician advises the parents of a normally developing and otherwise healthy twelve-month old son that they should refuse the MMR (measles, mumps, rubella) vaccine on

¹⁰⁶ Sugerman, *supra* note 28. See also section II.b.1 above.

¹⁰⁷ *Who Should Not Get Vaccinated with these Vaccines?*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/vaccines/vpd-vac/should-not-vacc.htm> (last visited ---, 2014).

the basis that is unnecessary and a possible contributor to neurological disorders, including autism.¹⁰⁸ The physician does not, however, inform the parents about the risks of refusing the vaccine, including the potential complications that can come from the diseases themselves. These parents reasonably rely on the advice of the pediatrician and decline the MMR vaccine. Their child then develops the measles and is harmed himself, or infects another who is harmed in turn.

Given the framework above, it is extremely likely that the physician would be liable—in fact, it’s the easiest case so far. The practice guidelines and standards pertaining to childhood immunizations are the standard of care by which the physician’s treatment is judged.¹⁰⁹ Under NVAC Standard #1, “all health care professionals who provide primary care to children and adolescents should always include routinely recommended vaccines as a part of the care that they deliver in the medical home.”¹¹⁰ The MMR vaccine is one of the routinely recommended vaccines.¹¹¹ The failure to include this vaccination in the medical care provided to the child goes against the well-recognized standard of care for pediatrics.

Moreover, in the foregoing example, the pediatrician has given the advice to avoid immunization to a child who has no apparent medical reason not to receive the vaccine.

¹⁰⁸ Which is, again, untrue. For a thorough discussion, see Stanley Plotkin et al., *Vaccines and Autism: A Tale of Shifting Hypotheses*, 48 CLINICAL INFECTIOUS DISEASES 458 (2009); Joelle Anne Moreno, *Toxic Torts, Autism, and Bad Science: Why the Courts May Be Our Best Defense Against Scientific Relativism*, 40 NEW ENG. L. REV. 409, 412-415 (2006).

¹⁰⁹ See *Matthews v. Aganad*, 914 N.E.2d 1233 (Ill. 2009).

¹¹⁰ *NVAC Standard 1*, AM. ACAD. OF PEDIATRICS (last updated June 2013), <http://www2.aap.org/immunization/pediatricians/NVACStandards/NVACStandard1.pdf>.

¹¹¹ 2014 Recommended Immunizations for Children from Birth through 6 Years Old, available at: <http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf> (last visited August 29, 2014)

According to NVAC Standard #6, “Health care professionals assess for and follow only medically accepted contraindications.”¹¹² This means that a physician should only recommend against vaccination where the child has a recognized medical reason to avoid vaccination. Recognized medical contraindications are those that are established by the Centers for Disease Control, and include such things as previous serious allergic reactions (anaphylaxis), age or known immunodeficiency.¹¹³

Thus, in this earlier example, the pediatrician, in advising against the use of a recommended childhood vaccine, has fallen below the standard of care. He has not only advised his patients in direct contradiction to the NVAC standards, he has also practiced medicine in a way that deviates from the customary practice. As such, he can, and should, be liable for injury caused by the child’s infection with the relevant vaccine-preventable disease.¹¹⁴

What of the physician who simply advises a delayed or alternative vaccination schedule? Pediatricians and family practitioners who look askance upon the recommended childhood immunizations may not necessarily advocate against the use of childhood vaccines in their entirety. One growing approach is what is referred to as the “alternate schedule” or “delayed schedule,” which has been brought into popular culture

¹¹² *NVAC Standards 5 and 6*, AM. ACAD. OF PEDIATRICS (last updated Sept. 2013), <http://www2.aap.org/immunization/pediatricians/NVACStandards/NVACStandard5and6.pdf>.

¹¹³ *Chart of Contraindications and Precautions to Commonly Used Vaccines*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications-vacc.htm> (last visited ----, 2014).

¹¹⁴ Let’s not forget, that from an ethical standpoint, the physician is bound by the principle of “doing no harm.” Advising against vaccination, without a valid medical basis, also violates that basic ethical principle.

through the work of pediatrician Bob Sears.¹¹⁵ Dr. Sears argues that the CDC's recommended schedule may overwhelm a child's immune system, stating "it has also been my experience that giving five or six vaccines at a time can increase the likelihood of a severe reaction."¹¹⁶ Note that this statement rests entirely on anecdotal evidence, which has no clearly defined basis.

The popularity of the alternate schedule is growing, with 1 in 10 parents currently using one.¹¹⁷

While an increasing choice for some parents, delayed or alternate vaccine schedules are not endorsed by the AAP nor by the NVAC. Specifically, NVAC Standard # 11 advises "Healthcare professionals [to] simultaneously administer as many indicated vaccine doses as possible [at the same visit]."¹¹⁸ In part, this is because "administration decreases the number of visits needed and the potential for missed doses and enables earlier protection."¹¹⁹ The AAP specifically advises against the use of a delayed or alternative schedule.¹²⁰ According to an AAP policy statement, delaying vaccines is not

¹¹⁵ For an analysis and detailed critique of what Dr. Sears does, see Paul A. Offit & Charlotte A. Moser, *The Problem With Dr Bob's Alternative Vaccine Schedule*, 123 PEDIATRICS 164 (2009).

¹¹⁶ *American Academy of Pediatrics 2007 Vaccine Schedule*, ASKDRSEARS.COM, <http://www.askdrsears.com/topics/health-concerns/vaccines/american-academy-pediatrics-2007-vaccine-schedule> (last visited ---, 2014); see also *American Academy of Pediatrics 2011 Vaccine Schedule*, ASKDRSEARS.COM, <http://www.askdrsears.com/topics/health-concerns/vaccines/american-academy-pediatrics-2011-vaccine-schedule> (last visited ---, 2014).

¹¹⁷ Amanda F. Dempsey et al., *Alternative Vaccination Schedule Preferences Among Parents of Young Children*, 128 PEDIATRICS, no. 5 (Nov. 2011). <http://pediatrics.aappublications.org/content/early/2011/09/28/peds.2011-0400.abstract>.

¹¹⁸ *NVAC Standards 11 & 13*, *supra* note 51.

¹¹⁹ *Id.*

¹²⁰ *The Childhood Immunization Schedule: Why Is It Like That?*, AM. ACAD. OF PEDIATRICS (Oct. 2008), <http://www2.aap.org/immunization/families/Vaccineschedule.pdf>.

recommended for several reasons, including: 1) there is no scientific basis for the delayed schedule; 2) there is no evidence that the delayed schedule protects children as well as the recommended schedule; 3) delaying vaccination not only leaves the child vulnerable to vaccine-preventable diseases, but also increases the opportunity for the disease to spread within the community at large (particularly if many other families also start following the delayed schedule).¹²¹

If a physician advises a pediatric patient's family to vaccinate according to an alternative schedule, he is doing so on the basis of opinion, and not medical or scientific evidence. A three-year-old who has not been fully vaccinated against the measles because his parent has followed an alternate vaccine schedule is at a much higher risk of acquiring the disease than a vaccinated child. This is particularly true if the community in which the child lives is experiencing a measles outbreak. Children under five are at a much higher risk of complications from measles.¹²² If a child contracts a vaccine-preventable illness because his physician advised against following the recommended schedule, the physician should be held liable for falling below the standard of care. If the community is experiencing an outbreak and the physician still supports delay or non-vaccination, that failure could be viewed as "conscious indifference to the welfare" of the child and could even provide the grounds for a finding of gross negligence.¹²³

¹²¹ *Id.* For additional critiques of delayed schedules, see Michael J. Smith, *Alternative Schedules: Why Not?*, in *VACCINOPHOBIA AND VACCINE CONTROVERSIES OF THE 21ST CENTURY* (Archana Chatterjee ed. 2013); Kristen A. Feemster & Paul A. Offit, *Delaying Vaccination Is Not a Safer Choice*, 167 *JAMA PEDIATRICS* 1097 (2013).

¹²² *EPIDEMIOLOGY AND PREVENTION OF VACCINE-PREVENTABLE DISEASES*, *supra* note 10, p. 12.

¹²³ See J. Brad Kallmyer, Note, *A Chimera in Every Sense: Standard of Care for Physicians Practicing Complementary and Alternative Medicine*, 2 *IND. HEALTH L. REV.* 225 (2005).

Note that the fact that the community may have a norm of delayed schedules will not affect the physician's duties. The physician is held to the professional standard of care, not the community norm, as explained. If the community believes in faith healing, a physician that recommended prayer instead of insulin for a diabetic would still be liable. Similarly, a physician is not off the hook merely because members of the community support a delayed schedule. The situation may be a little different if the custom is among physicians. In that case, the standard of care—local, state or national—would be determinative. But there is no evidence of widespread recommendation of alternate schedules by physicians: the desire for such schedules seems to be parent-initiated. For example, a recent study showed that 61% of a set of Washington state physicians interviewed were comfortable with an alternate schedule if, and only if, requested by the parents.¹²⁴ In other words, the physicians would not offer an alternative schedule, but would be willing to follow one if parents asked for it.¹²⁵

Notably, however, even these physicians were reluctant to agree to delay or avoid vaccines for some of the most deadly bacterial diseases.¹²⁶

As discussed previously, in the context of infectious diseases, the duty owed by the physician may extend beyond the pediatric patient to third parties as well.¹²⁷ Although the physician's duty of care generally is limited to the person with whom the physician

¹²⁴ Aaron Wightman et al., *Washington State Pediatricians' Attitudes Toward Alternative Childhood Immunization Schedules*, 128 PEDIATRICS 1094, 1096 (2011).

¹²⁵ *Id.*

¹²⁶ *Id.*, p. 1097.

¹²⁷ Jeffrey W. Burnett, Comment, *A Physician's Duty to Warn a Patient's Relatives of a Patient's Genetically Inheritable Disease*, HOUS. L. REV., 559, 563-569 (1999).

has a patient-physician relationship (here the child), the duty of care has been expanded, in some circumstances, to include the patient's family, and beyond that, to third parties.¹²⁸

Courts acknowledged a duty to warn of the risk of incurring an infectious disease from the patient. As explained by the Arkansas Supreme Court in 1921:

On account of his scientific knowledge and his peculiar relation, an attending physician is, in a certain sense, in custody of a patient afflicted with infectious or contagious disease. And he owes a duty to those who are ignorant of such disease, and who by reason of family ties, or otherwise, are liable to be brought in contact with the patient, to instruct and advise them as to the character of the disease.¹²⁹

As already discussed, this duty of care should be extended to the prevention of infectious disease as well, and to failure to vaccinate. Thus, if a third party contracts a vaccine-preventable disease through the unvaccinated child, and the physician failed to warn the family of this potential risk, liability might be imposed upon the physician.

2. Informed consent

One theory under which a physician can be liable for failing to vaccinate or advising an alternative schedule is negligent medical performance. A second theory would be malpractice on the grounds that the healthcare provider failed to obtain

effrey W. Burnett, Comment, *A Physician's Duty to Warn a Patient's Relatives of a Patient's Genetically Inheritable Disease*, HOUS. L. REV., 559, 563-569 (1999).

¹²⁸ *Davis v. Rodman*, 227 S.W. 612 (Ark. 1921) (It would likewise be their duty to exercise reasonable care to advise members of the family and others, who are liable to be exposed thereto, of the nature of the disease and the danger of exposure.); *Tenuto v. Lederle Lab.*, 687 N.E.2d 1300 (N.Y. 1997).

¹²⁹ *Davis*, 227 S.W. at 391-92.

informed consent from the patient. This theory is rooted “in patient autonomy and is characterized by an exchange of material information between physician and patients such that the patient can make an informed health care decision.”¹³⁰

The conversation regarding vaccination and informed consent typically focuses on the need for patients to be given informed consent when choosing to accept a particular vaccine.¹³¹ While this is no doubt critical, another equally important concept has largely been ignored.¹³² Few have discussed the role informed consent plays when a physician urges or recommends delaying, or even refusing, certain vaccinations. If the goal of informed consent is to give the patient all the information they need in order to make an informed decision about a healthcare option, then this must include information about the risks of choosing not to vaccinate.¹³³ The facts about the diseases that are being targeted by each vaccine, the symptoms and potential complications, must be included in any discussion about vaccination in order for parents to make an informed decision about whether to accept or refuse immunization.

¹³⁰ James A. Bullen, Jr., *Complementary and Alternative Medicine: Ethical and Legal Aspects of Informed Consent to Treatment*, 24 J. Legal Med. 331,333 (Sept. 2003).

¹³¹ See Abigail English et al., *Legal Basis of Consent for Healthcare and Vaccination for Adolescents*, 121 PEDIATRICS S85, S85 (Jan. 2008).

¹³² The federal government already requires that physicians who provide immunizations give information on the risks associated with a particular vaccine. 42 U.S.C.A. §300aa-26 (d) requires that materials developed by the Secretary of the Department of Health and Human Services be provided to legal representatives of a child before vaccination. These materials are currently titled “Vaccine Information Sheet” (VIS) and available through the CDC. *Vaccine Information Statements*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/vaccines/hcp/vis/index.html?s_cid=cs_748 (last visited ---, 2014).

¹³³ Joan Gilmour et al., *Childhood Immunization: When Physicians and Parents Disagree*, 128 PEDIATRICS S167, S169 (2010) (“When advising parents, health care practitioners should provide full and complete information about the diseases targeted and the risks and benefits of proceeding with immunization or refusing it.”).

If we use the professional standard of care, the AAP suggestion of a refusal form is good evidence that the professional organization expects physicians to provide parents with information about the risks of not vaccinating. If we use the patient standard of care, the risks of diseases are almost certainly material risks that should be discussed. Many parents who decline vaccination are “often unaware of the risks to children, families, and communities posed by vaccine-preventable diseases.”¹³⁴ If the pediatric health care provider advises against a particular vaccine, without also advising the parents about the risks, complications, and contagious nature of that disease, the parent cannot possibly be making an “informed” decision.¹³⁵ The right of “self-decision” can be “effectively exercised only if the patient possesses enough information to enable an intelligent choice.”¹³⁶ In fact, failing to warn the parent about the risk of not vaccinating—or worse, providing inaccurate information—is not promoting informed consent. In the words of a well-known science blogger, it’s promoting “misinformed consent,”¹³⁷ (or we may say

¹³⁴ Janet L. Engstrom, *Not My Child: Parental Refusal of Vaccinations for Child*, 54 J. MIDWIFERY & WOMEN’S HEALTH 82 (2009), available at <http://www.sciencedirect.com/science/article/pii/S1526952308002560>.

¹³⁵ Indeed, even alternative healthcare practitioners owe a duty to explain to their patients the risk of choosing the alternative treatment versus conventional medicine. *See* Charrell v. Gonzalez, 173 Misc.2d 227 (N.Y. June 10, 1997); Anna M. Richardson, Note, *Informed Patients go Homeo Happy: Applying the Doctrine of Informed Consent to Homeopathic Practitioners*, 34 OHIO N.U. L. REV. 593 (2008) (A homeopathic practitioner should be required to tell his patient of the alternative treatments offered by the competing conventional school of medicine. This includes alternatives which may even pose more risks than the treatment proposed.).

¹³⁶ *Canterbury v. Spence*, 464 F.2d 772,787 (D.C. Cir. 1972); *see also* Bulen, *supra* note 114, at 339 (“This right can only be exercised if the patient possesses enough information to make an intelligent health care choice, and consequently, the physician's disclosure duty must meet the patient's informational needs.”).

¹³⁷ “*Misinformed Consent*” *Rears its Ugly Head in Pediatrics*, SCIENCEBLOGS.COM (Nov. 9, 2011) <http://scienceblogs.com/insolence/2011/11/09/misinformed-consent-rears-its-ugly-head/>.

“misinformed refusal”)¹³⁸ leading patients to make a decision on the basis of misinformation. Being manipulated is the opposite of autonomy.

Even if the behavior stops short of actual misrepresentation—which is discussed in the next section—it can violate the basis for informed consent. Presenting information out of context, in ways that can mislead readers, is a good example. Consider again Dr. Bob Sears. Dr. Sears stated in his Facebook post at the beginning of this article that “No one has died from measles in the U.S. in over 10 years” without including the context of high vaccination rates and low disease incidence, and ignoring the deaths in Europe as a result of falling vaccination rates and the subsequent measles outbreaks. In that, he misleadingly downplayed the risks of measles when in fact a child can die from measles. Let the rates go high enough, and we will see deaths (and other harms). Similarly, in *The Vaccine Book*, Dr. Sears made many problematic claims, such as overstating aluminum exposure, as Offit and Moser describe him doing:

Sears’ main argument for spacing out vaccines is to avoid giving infants too much aluminum at one time, writing, “When a baby gets the first big round of shots at two months, the total dose of aluminum can vary from 295 micrograms . . . to a whopping 1,225 micrograms if the highest aluminum brands are used and a hep B vaccine is also given. . . . These doses are repeated at four and six months.” Extrapolating studies of patients undergoing hemodialysis and severely premature infants to healthy newborns, Sears claims that these quantities might be unsafe. However, Sears fails to put aluminum exposure in context. By 6 months of age, infants typically ingest 6,700 micrograms of aluminum in breast

¹³⁸ We are grateful to Craig Egan for this term.

milk, 37,800 micrograms in infant formula, or 116,600 micrograms in soy-based formula.¹³⁹

Again, by suggesting that studies of patients with kidney problems and immature infants can teach us about aluminum exposure in healthy infants, and by ignoring the much larger exposure to aluminum from other sources, Dr. Sears creates a fear of vaccines that has no basis, and readers of his book may be deterred from vaccinating because of this manufactured fear. The focus of this article is not on his book: advice in books raises a different set of issues than advice from doctor to patient.¹⁴⁰ But if Dr. Sears says similar things to patients, so that the book reflects the way he practices, he is misinforming patients and leading them to make substandard choices for themselves and their children. Whether we use the professional standard of care or the patient standard of care, at the least a patient should not be given inaccurate information.

From another angle, we might consider the issue of informed consent as one involving the information that is required when offering an alternative or unconventional therapy. Because following the recommended vaccine schedule is the conventional and recommended course of care, advising against vaccination could be viewed as an unconventional approach. As such, the risks of following the unconventional approach must be made clear to the patient. Although the issue has not received much judicial attention, at least one court has held that a physician can be liable for lack of informed

¹³⁹ Offit & Moser, *supra* note 98, at 167..

¹⁴⁰ See *Smith v. Linn*, 526 Pa. 47 (1991); Heather Appleton, *The First Amendment: Is the Freedom of Speech More Important Than the Protection of Human Life*, 12 LOY. L.A. ENT. L. REV. 585 (1992).

consent when performing an alternative medical treatment without providing information about the benefits of conventional treatment.¹⁴¹

A critical goal of informed consent is the reduction of medical injuries.¹⁴² For this to be achieved it is necessary to include information about the risks of medical injury that come with refusing or delaying vaccination.

II.d. Actual Misrepresentation

Imagine a mother who takes her two-month old for her well baby visit with a board certified pediatrician. At the visit, the mother asks the doctor which vaccinations are recommended at that time and whether her daughter will receive these vaccines. Although the AAP's recommended schedule would have the child receive five vaccines, including one against pertussis, the pediatrician's recommendation to the mother is not to administer any vaccines until the child is older because a two month old's body cannot handle the "toxins" in vaccines. Suppose the pediatrician also tells the mother that pertussis is an "old" disease and that it is generally quite mild. The mother relies on this advice and delays vaccination. At six months old, the child contracts pertussis and suffers lasting harm. Had the pediatrician followed the recommended schedule, the child would have been fully vaccinated against pertussis by this age. What recourse, if any, does the

¹⁴¹ *Charrel v. Gonzalez*, 173 Misc.2d 227 (N.Y. Sup. Ct. 1997) (lack of informed consent when doctor gave coffee enema to treat cancer without warning of risk of going with alternative treatment).

¹⁴² Symposium, *Eliminating Legal, Regulatory, and Economic Barrier to Biodefense Vaccine Development*, 8 J. HEALTH CARE L. & POL'Y 71 (2005).

mother have against the pediatrician for misrepresenting the danger of vaccines and downplaying the risks of the disease?

Although the First Amendment guarantees freedom of speech, it does not necessarily afford protection for those who make false and misleading statements that cause physical harm.¹⁴³ Pursuant to the Restatement of the Law of Torts (Second) §311, civil liability may be imposed on a person who “negligently gives false information to another” where physical harm occurs that is “caused by action taken by the other in reasonable reliance upon such information.”¹⁴⁴ The negligence may be the result of failing to exercise reasonable care in: “(a) ascertaining the accuracy of the information, or (b) in the manner in which it is communicated.”¹⁴⁵ This tort can apply to any person, “who, in the course of an activity which is in furtherance of his own interests, undertakes to give information to another, and knows or should realize that the safety of the person of others may depend upon the accuracy of the information.”¹⁴⁶

The speaker need not even have a special relationship with the individual who is harmed. For instance, a healthcare professional who uses the internet to offer anti-vaccine advice could be held liable for harm caused to a person who reasonably relied on this professional’s inaccurate medical advice.¹⁴⁷ If a special relationship is not even a requirement, how much more applicable is the tort in the context of a doctor-patient

¹⁴³ For a more detailed discussion see Amanda Z. Naprawa, *Don’t Give Your Kid That Shot!: The Public Health Threat Posed By Anti-Vaccine Speech And Why Such Speech Is Not Guaranteed Full Protection Under The First Amendment*, 11 CARDOZO PUB. L. POL’Y & ETHICS J. 473 (2013) .

¹⁴⁴ RESTATEMENT (SECOND) OF TORTS § 311(1)(a)(b).

¹⁴⁵ *id.*

¹⁴⁶ RESTATEMENT (SECOND) OF TORTS § 311 cmt. b.

¹⁴⁷ See Naprawa, *supra* note 140.

relationship? The tort has significant application to individuals who provide information as part of their profession, such as physicians.¹⁴⁸ This is both because of the physician's relationship of trust with the patient, as well as his superior knowledge base and training.

Could the mother of the child harmed by pertussis prevail in a suit against the pediatrician for his negligent misrepresentation? In order to prevail, she would need to demonstrate that the following elements occurred: 1) false information, 2) given negligently, 3) reasonable reliance, 4) causation, and 5) harm.¹⁴⁹ In this case, it is likely that the mother could prevail. As to the first element, the plaintiff could easily show that the physician provided false information (the claim that the body of a two-month old infant cannot handle the "toxins" in vaccines and the claim that pertussis is a mild disease). The AAP recommended schedule has been repeatedly reviewed and studied and the overwhelming scientific consensus is that the schedule is safe and appropriate (even for two-month olds).¹⁵⁰ The pediatrician also misinformed the mother about the risks of

¹⁴⁸ See *Morgan v. Christman*, 1990 U.S. Dist. LEXIS 12179 (D. Kan. July 20, 1990) (recognizing a cause of action pursuant to Restatement §311 against a physician who negligently misrepresented that a particular fertility treatment would not cause multiple gestation; the drug did cause multiple gestation and the children were born prematurely and with permanent disabilities. The court stated there should be recognized a cause of action for one "who allegedly conveyed false information in a negligent manner to a patient where the patient relied upon that information to his or her physical detriment"); see also RESTATEMENT (SECOND) OF TORTS §311 cmt. b (year) (provides that the rule has "particular application where it is a part of the actor's business or profession to give information upon which the safety of the recipient or a third person depends," such as a physician.).

¹⁴⁹ See *Isham v. Padi Worldwide Corp.*, 2008 U.S. Dist. LEXIS 27325, at *31-32 (D. Haw. Apr. 2, 2008) (a Section 311 negligent misrepresentation claim contains the following elements: "(1) false information be supplied as a result of the failure to exercise reasonable care or competence in communicating the information; (2) the person for whose benefit the information is supplied suffered the loss; and (3) the recipient relies upon the misrepresentation."); see, e.g., MERCOLA.COM, <http://www.mercola.com> (last visited March 27, 2013).

¹⁵⁰ *The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies*, INSTITUTE OF MEDICINE (Jan. 2013), available at http://www.iom.edu/~media/Files/Report%20Files/2013/Childhood-Immunization-Schedule/ChildhoodImmunizationScheduleandSafety_RB.pdf ("Upon reviewing stakeholder concerns and scientific literature regarding the entire childhood immunization schedule, the IOM committee finds no evidence that the schedule is unsafe.").

pertussis by calling it a “mild disease.” Secondly, the information was given negligently because of the physician’s failure to ensure the accuracy of the information (or worse, given even though the doctor knew respectable medical texts disagree).¹⁵¹ Third, there should be no difficulty establishing that the mother reasonably relied on advice of the pediatrician: the appropriate source for medical advice to a patient is his/her doctor, and a patient (or in this case the minor patient’s parent) should be able to rely on that doctor’s competence in giving advice.¹⁵² The fourth element, causation, would also likely be easy to demonstrate: the false information about the risks of the vaccine and the low-risk of the disease directly resulted in the mother’s failure to vaccinate and the failure to vaccinate directly and naturally resulted in illness.¹⁵³ Finally, the element of harm would be met.

The physician who negligently misrepresents the dangers of vaccines, or who downplays the risks of vaccine-preventable disease, should be liable when that misinformation causes physical harm. Not only would the viability of this cause of action offer protection for patients, it would also encourage physicians to accurately acquire and disseminate information. This is particularly important when the health information being conveyed affects not just the patient, but potentially anyone who comes into contact with

¹⁵¹ RESTATEMENT (SECOND) OF TORTS § 311(2)(a)(b).

¹⁵² See *Bloskas v. Murray*, 646 P.2d 907, 915 (Colo. 1982) (recognizing a cause of action for negligent misrepresentation against a physician who negligently misrepresented his experience in performing ankle surgery; the representation was relied upon and plaintiff’s ankle had to be amputated); *Skillings v. Allen*, 173 N.W. 663 (Minn. 1919) (physician liable for negligently misrepresenting that a patient with scarlet fever was not a danger to those who came into contact with her).

¹⁵³ One caveat might be if the physician can demonstrate that the parent was already vaccine-hesitant, and would have made the decision to refuse vaccination regardless of the physician’s advice.

that patient, as is the case with vaccination. Not to mention the fact that vaccine-preventable diseases can have devastating consequences.

The tort of negligent misrepresentation covers not only harm to patients, but also harm to “such third persons as the actor should expect to be put in peril by the action taken.”¹⁵⁴ In the context of infectious diseases, this is a pretty easy extension: by their nature, infectious diseases can infect others. For example: If a child was left unvaccinated against measles because a doctor falsely advised that the MMR can occasionally cause autism, and that child caught measles and infected another, that other has a legitimate claim of negligent misrepresentation against the doctor.

Few court cases have tested this theory of liability, particularly in the context of anti-vaccine medical advice. It is inevitable that a physician, faced with a claim from a third party for negligent misrepresentation, would raise complaints of free speech issues. Doesn't imposing liability on a physician for harm to a third party, based on a conversation he had with a patient, potentially lead to a chilling effect leading physicians to speak less to avoid potential liability? Because speech is constitutionally protected, does the injured party have to establish that the physician spoke with actual malice?¹⁵⁵

Although a possible defense, constitutional claims against the tort of misrepresentation are unlikely to be successful. Unlike a book publisher who may have no actual knowledge of the words being spoken by an author, a physician who gives anti-vaccine advice knows exactly what is being said.¹⁵⁶ Unless he is completely out of touch

¹⁵⁴ RESTATEMENT (SECOND) OF TORTS §311.1(b).

¹⁵⁵ As he would, for example, in a libel suit. See: *St. Amant v. Thompson*, 390 U.S. 727, 731 (1968).

¹⁵⁶ Naprawa, *supra* note140

with the appropriate medical standards (malpractice in itself perhaps), the physician giving inaccurate medical advice knows he is going against medical standards. He is fully aware that his advice is based on unsubstantiated information. And providing accurate advice is part of his professional obligation and duty.

Promoting this kind of misinformation can even lead to punitive damages, since it so grossly deviates from the statements of the AAP, CDC and other health experts, and goes against the evidence. The purpose of punitive damages is deterrence.¹⁵⁷ Imposing punitive damages in this type of case would be appropriate and would likely lead to fewer physicians knowingly giving inaccurate medical advice to their patients. Furthermore, where the defendant's action causes physical harm to a child, and evidences an utter disregard for the safety and health of others, punitive damages are often appropriate.¹⁵⁸

Conclusion:

With power comes responsibility. People trust doctors and the advice they give. In the context of vaccines, the advice doctors should give is clear: because the risks of modern vaccines are so small, and so much smaller than the risks of not vaccinating, and because the professional bodies all support vaccinating on schedule, doctors should advise patients to vaccinate on schedule. That's the standard of care. A doctor who fails to follow that does so at his/her peril: if harm results to a patient or to a third party, the

¹⁵⁷ *State Farm v. Campbell*, 538 U.S. 408, 409 (2003).

¹⁵⁸ *Id.* at 419 (appropriateness of punitive damages includes consideration of “the harm caused was physical as opposed to economic; the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was the result of intentional malice, trickery, or deceit, or mere accident.”).

physician should have to cover it. There is certainly good reason to demand that a doctor who actively advises deviations from the established vaccination schedule pay for any harms that result—depending on the nature of the advice and the content, punitive damages may be appropriate.

