Spring 2023

Ethical Implications of Covid-19 Vaccine Mandates

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The Ethical Implications of the COVID-19 Vaccine Mandates

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Abstract

This paper will explore different ethical theories, famous philosophers' viewpoints, and bioethical principles to conclude whether the COVID-19 vaccine mandates were ethical and under what conditions such a determination may change. This paper will start with a quick timeline of the COVID-19 pandemic ending with the implementation of the vaccine mandates. The paper will review the definitions of a "mandate" and "vaccine" since many of the principles that will be discussed depend rigorously on these terms. The paper will then discuss three ethical theories relevant to vaccine mandates: Utilitarianism, Kantianism, and Casuistry, and the major proponents or founders of each, and finally examine the vaccine mandates through the filter of these theories to determine the ethical implications of the vaccine mandates. This paper will then look at more current bioethical principles and rules such as autonomy, nonmaleficence, beneficence, and justice and, again, break down the vaccine mandates in terms of these principles. This paper will also provide a current case study on organ transplants surrounding bioethical principles, the COVID-19 vaccine mandates, and how mandating the COVID-19 vaccines impacted healthcare workers. Finally, based on the principles and ideals surveyed in this paper, an overarching verdict concerning the ethics surrounding the COVID-19 vaccine mandate will be presented.

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Introduction

The COVID-19 pandemic threw the whole world into a frenzy. It has been just over 100 years since the world last saw a pandemic of this magnitude. In its first year, the new virus infected an estimated 100 million Americans, five times as many as usually infected by the flu in an average year. Countries worldwide shut down and implemented lockdowns, mask mandates, and vaccine mandates to help stop the pandemic. However, these actions had little effect, as more people died in year two than in year one.

Moreover, with mandates came public outcry. We were told that it was the morally right thing to get vaccinated. We heard and saw "Get the vaccine to save lives," "Together we can beat this! Get vaccinated against COVID-19 today," and many other quotes and sayings. Celebrities and presidents made it a point to get vaccinated in front of live TV to help encourage vaccinations. Despite all the publicity, some people refused or did not want to get vaccinated. Those people claimed, "It was their body, their choice," "I have an immune system, no vaccine needed," and "The vaccines are neither safe nor effective." The vaccine mandates caused so much controversy worldwide that they became a political issue. People claimed the vaccine mandates were ethical based on their morals and beliefs, while others claimed it was unethical based on their morals and beliefs. In this paper, I plan to examine the ethical arguments on both sides of the vaccine mandates applied throughout the pandemic.

Background and Timeline for the COVID-19 Pandemic

In December 2019, an atypical pneumonia-like virus was detected in China's Hubei Province, which was then registered by the World Health Organization (WHO) in Wuhan, China. Symptoms of this disease included shortness of breath, fever, and cough. According to the WHO,

the cases seemed connected to the Huanan Seafood Wholesale Market (Centers for Disease Control and Prevention, 2022). In January 2020, the WHO named the virus "2019 Novel Coronavirus" or "2019-nCov" for short as they determined it was from the Severe Acute Respiratory Syndrome (SARS) Coronavirus 2 (CoV-2) virus. We would soon get the name" COVID-19" from the WHO, where "CO" refers to Corona, "VI" virus, "D" for disease, and 19 for the year (late 2019) the disease was first recognized. In January 2020, we saw the first reported deaths attributed to the virus in China and several other countries, such as Thailand, Japan, and South Korea. In that same month, the U.S. started reporting its first known cases. In February, all flights originating from China were routed to 11 specific airports in the U.S. for enhanced screening, and 14 days of mandatory quarantine were established for U.S. citizens returning from China (*DHS Issues Supplemental Instructions, 2020)*. Italy, in particular, became an early hot spot for COVID-19 and was hit particularly hard by the virus starting in February.

With more than 118,000 cases in 114 countries and 4,291 deaths in March, the WHO declared COVID-19 a pandemic (Centers for Disease Control and Prevention, 2022). Also, in March, particular states in the U.S. started to implement shutdowns to stop the spread of the virus; government facilities, public places, and schools were the main focus of these shutdowns. Social distancing and masks started to become normal. In record time, Moderna Therapeutics began the first human trials for a vaccine to protect against COVID-19. By April, more than 1 million cases were confirmed worldwide, and the U.S. had 500,000 confirmed cases with more than 18,600 deaths, making the U.S. another global hot spot for the virus (Centers for Disease Control and Prevention, 2022). The first shortages of personal protective equipment were reported in the U.S., yet some states started to reopen partially. At the end of April, President Trump launched Operation Warp Speed, an "initiative to produce a vaccine against the virus as quickly as possible.

The operation initially funded the development of six promising vaccine candidates while still in the clinical trial phase, including the Pfizer-BioNTech and Moderna mRNA (messenger Ribo Nucleic Acid) vaccines (Centers for Disease Control and Prevention, 2022).

In May 2020, the Federal Drug Administration (FDA) authorized the first COVID-19 test with the option of using home-collected saliva samples. AstraZeneca received more than $1 billion from the U.S. government in funding for developing a vaccine, with the first dose due in September 2020. In June, the U.S. surpassed 2 million confirmed cases of COVID-19, and the Department of Health and Human Services (HHS) announced that the vaccines would be provided free of charge to older adults and other groups experiencing disproportionate impacts from the pandemic (Centers for Disease Control and Prevention, 2022). In July, the U.S. surpassed 3 million confirmed cases, and the WHO announced that the virus could be transmitted through the air and was most likely being spread by asymptomatic people. At this point, southern states had the highest number of confirmed cases. Towards the end of July, the Department of Defense (DOD) and HHS reached a deal with Pfizer-BioNTech for the delivery and distribution of 100 million doses of their vaccine, which would be due in December 2020 if the vaccine was confirmed to be safe and effective (Centers for Disease Control and Prevention, 2022).

In August, the Trump administration agreed to pay $1.5 billion to Moderna for 100 million doses of their vaccine. The Centers for Disease Control and Prevention (CDC) released data signifying that most COVID-19-positive people are infectious to others for up to 10 days after symptoms first appear. However, they also said that individuals with severe illness or immunocompromised could be infectious for up to 20 days. In the same month, COVID-19 became the third leading cause of death in the U.S., and confirmed cases exceeded 5.4 million (Centers for Disease Control and Prevention, 2022). In September 2020, the U.S. and China

declined to join the COVID-19 Vaccine Global Access Facility (COVAX), a global program to develop and distribute vaccines worldwide. Pfizer-BioNTech expanded Phase 3 clinical trials of its COVID-19 vaccine to 44,000 participants. The Pfizer-BioNTech vaccine is a 2-shot series given three weeks apart and must be stored at temperatures lower than -70 degrees Celsius (-94 °F). Johnson & Johnson also began Phase 3 clinical trials of its COVID-19 vaccine, with more than 60,000 participants (Centers for Disease Control and Prevention, 2022). The Johnson and Johnson vaccine required only one shot. Reported deaths worldwide reached more than 1 million, while the death toll in the U.S. surpassed 200,000 people. The HHS announced a plan to make the vaccines free in the U.S. (Centers for Disease Control and Prevention, 2022).

In November, studies were released that indicated indoor gatherings were the cause of most COVID-19 cases. These studies were critical to making vaccines first available to the public in record time. Moderna's COVID-19 vaccine was 95.4% effective in its trials, and Pfizer-BioNTech's vaccine was 95% effective in its 44,000-person trial (Centers for Disease Control and Prevention, 2022). In December 2020, the FDA issued an "emergency use authorization" (EUA) for the Pfizer-BioNTech COVID-19 vaccine, and the Advisory Committee on Immunization Practices (ACIP) recommended it for all people aged 16 years or older for the *prevention* of COVID-19. The FDA also issued an EUA for the Moderna vaccine, and the ACIP recommended the Moderna vaccine for people aged 18 years or older to prevent COVID-19. The ACIP recommended that healthcare professionals and older people living in nursing homes or long-term care facilities were to be offered a vaccine first in the initial phases of the COVID-19 vaccination program; the CDC also recommended that people 70 years and older living in multi-generational homes should be given priority to the vaccines as they became available (Centers for Disease Control and Prevention, 2022). Towards the end of December, the Trump administration

purchased 100 million additional doses of the Pfizer-BioNTech vaccine. More than 1 million doses of the COVID-19 vaccine had been administered in the U.S. in just ten days. Healthcare workers and older adults living in long-term care facilities were the first to be vaccinated, with the goal of vaccinating every person in the U.S. as soon as possible. The AstraZeneca COVID-19 vaccine was authorized for emergency use in the U.K. Within a week, 530,000 doses were available for adults 80 years and older, healthcare workers, and care-home residents (Centers for Disease Control and Prevention, 2022). As a side note, the AstraZeneca COVID-19 vaccine was never authorized in the U.S. The company eventually gave up trying to gain approval in November of 2022 due to waning interest and demand for COVID-19 vaccines (Reuters, 2022).

In December 2020, since supply at the time was limited, the CDC also released a report for the phasing of the vaccination allocation: Phase 1a—healthcare personnel and residents in long-term care facilities, 1b—essential workers and everyone older than 75 years of age, 1c—all person's aged 65-74 and all people 16-64 with a medical condition that increases their risk of severe disease from COVID-19, and 2—all people aged 16 and older not already recommended in phase 1. By the end of the year, 2.8 million people in the U.S. had received a COVID-19 vaccine dose (Centers for Disease Control and Prevention, 2022).

A variant of COVID-19, B.1.17/Alpha, sometimes referred to as the "alpha" variant, was first detected in the U.K. in September and was confirmed in the U.S. in December 2020. The alpha variant was considered 1.5 times more transmissible than earlier COVID variants, and the risk of it leading to death was around 1.6 times higher (Le Page & McNamara, 2021).

The race to see whether vaccinations could keep up with the different variants was now on. In January 2021, there were vaccine shortages (more people demanding vaccines than were available), and the reported death toll in the U.S. surpassed 400,000. The number of recorded cases

of COVID-19 reached more than 100 million, and roughly 23 million people in the U.S. had been vaccinated. More variants of COVID-19 were detected around the world. In February 2021, the FDA approved an emergency use authorization for the Johnson & Johnson one-shot COVID-19 vaccine for everyone 18 years and older. The death toll in the United States reached 500,000, while 4.3 million people in the U.S. have left the workforce since the start of the pandemic (Centers for Disease Control and Prevention, 2022).

By March, more than 100 million COVID-19 vaccine doses had been administered in the U.S., and the Biden administration announced a plan to make all adults eligible and able to receive a vaccine by May 1. The CDC endorsed that people who were fully vaccinated could be around others who were also fully vaccinated indoors without social distancing or masks. A CDC study found that the mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna) were highly effective at preventing infection with the SARS-CoV-2 virus in real-world situations and reduced the risk of infection by 90% (Centers for Disease Control and Prevention, 2022).

In April, the CDC allotted $3 billion additional funding for expanded COVID-19 vaccination programs. The FDA and CDC issued a joint statement on pausing the use of the Johnson & Johnson vaccine just two months after it was approved for emergency use because there were six rare cases of serious blood clots in people who received the shot. Nevertheless, after a thorough safety review, the ACIP and FDA recommended the continued use of the Johnson & Johnson vaccine in early May for all people 18 years and older “for whom other authorized or approved COVID-19 vaccines are not accessible or clinically appropriate” (FDA, 2022). However, by this point, the Johnson & Johnson vaccine was no longer readily offered by state and federal health agencies. At the same time, the CDC reported findings that the Pfizer-BioNTech and Moderna mRNA COVID-19 vaccines reduced the risk of hospitalization in people 65 years and

older by up to 94%. Moreover, in May 2021, the FDA and ACIP expanded the EUA (emergency use authorization) for the Pfizer-BioNTech vaccine to children 12-15 (Centers for Disease Control and Prevention, 2022).

By June, another variant of COVID-19, the delta variant, which was thought to have originated in India, became the dominant strain in the United States. The CDC reported that the Pfizer-BioNTech and Moderna vaccines reduced the risk of infection by 91% and protected against severe illness and hospitalization if a breakthrough infection did occur. In July 2021, the CDC and FDA released a joint statement assuring the public that people who have been fully vaccinated do NOT need a booster shot, yet urged everyone to re-mask indoors (Centers for Disease Control and Prevention, 2022).

In August, studies were released showing that unvaccinated people were more than twice as likely to be reinfected with COVID-19 than people who were fully vaccinated, implying the vaccines offered stronger protection than natural immunity alone, refuting years of research and science on natural immunity (Stein et al., 2023). The CDC also urged pregnant women to get the COVID-19 vaccine because the benefits of vaccination outweighed any known or potential risks to the unborn fetus. There was no evidence that the vaccine caused infertility issues in either men or women. The FDA also fully approved the Pfizer-BioNTech COVID-19 vaccine for everyone 18 years and older; full FDA approval (in contrast to the original EUA approval) “reinforces that the Pfizer-BioNTech COVID-19 vaccine has been shown to meet the agency’s high standards for safety, effectiveness, and consistent quality in manufacturing” (Centers for Disease Control and Prevention, 2022).

Nevertheless, just a month after insisting booster shots were unnecessary in August, the ACIP recommended an additional COVID-19 vaccine after the two-dose mRNA vaccine series

for all people with compromised immune systems (Centers for Disease Control and Prevention, 2022). The HHS, CDC, and FDA also released statements concluding that booster shots of the Pfizer-BioNTech, Moderna, and Johnson & Johnson vaccines were needed to protect against severe disease, hospitalization, and even death. Following this warning, in September 2021, the ACIP recommended the Pfizer-BioNTech COVID-19 vaccine boosters (a third shot) for all people ages 65 years and older, people 50-64 years with underlying medical conditions, residents of long-term care facilities, and people ages 18-49 with underlying medical conditions and who work in high-risk areas to be given at least six months after their primary vaccination. This was followed in October, with ACIP recommending a Moderna and Johnson & Johnson booster for all people ages 65 years older, people 50-64 years with underlying medical conditions, residents of long-term care facilities, and people ages 18-49 with underlying medical conditions and who work in high-risk areas to be given at least six months after their primary vaccination (Centers for Disease Control and Prevention, 2022).

In November 2021, the ACIP endorsed the Pfizer-BioNTech pediatric COVID-19 vaccine for all children ages 5-11. Another COVID-19 variant, Omicron, emerged. The CDC urged everyone 18 years and older who received a Moderna, Johnson & Johnson, or Pfizer-BioNTech vaccine to receive a booster after they were fully vaccinated. In December, the CDC and FDA expanded COVID-19 booster recommendations to everyone ages 16 and older. The recorded death toll surpasses 800,000, and one in every 100 people aged 65 years and older in the U.S. has died from COVID-19 (Centers for Disease Control and Prevention, 2022).

In January 2022, the ACIP shortened the recommended time between the primary vaccinations series and a booster shot from 6 months to 5 months for the Pfizer-BioNTech shot. The CDC updated its guidelines on masks, and the FDA updated the EUA for the Moderna

COVID-19 vaccine to shorten the time between the primary series of the vaccine and the booster dose from 6 months to five months. The FDA also fully approved the Moderna vaccine for all people ages 18 years and older; full FDA approval meant "the Moderna COVID-19 vaccine has been shown to meet the agency's high standards for safety, effectiveness, and consistent quality in manufacturing" (Centers for Disease Control and Prevention, 2022). In February, the CDC released several studies. One study showed that the vaccine boosters were safe and highly effective against severe disease even during the Omicron and Delta variant surges. Another study showed that maternal COVID-19 vaccination during pregnancy with an mRNA vaccine (Pfizer-BioNTech and Moderna) reduced the risk of hospitalizations.

In March, the WHO released data showing that the pandemic triggered an increase in depression and anxiety for young people and women worldwide. About 56% of the world was fully vaccinated by this point. The death toll globally was about 6 million, while there were about 450 million confirmed cases of COVID-19 (Centers for Disease Control and Prevention, 2022). Mask mandates officially ended in the United States in March 2022. The CDC released data showing that adults receiving three doses of the mRNA vaccines were 94% less likely to be put on a ventilator or die during the Omicron surge than unvaccinated people. The death toll in the United States reached 976,229 people (Centers for Disease Control and Prevention, 2022).

Also, in March 2022, the CDC recommended a second mRNA vaccine booster for immunocompromised people. The CDC encouraged adults who received a primary vaccine series and booster dose from Johnson & Johnson to receive a second booster dose from an mRNA vaccine. At this point, the CDC was fully behind the mRNA vaccines, recommending the original vaccine plus two boosters and those with the Johnson & Johnson vaccine to take an mRNA booster (Centers for Disease Control and Prevention, 2022).

In April 2022, the CDC released more data showing that the risk of cardiac complications in all age groups was higher after COVID-19 infection when compared to after mRNA COVID-19 vaccination. For the third year, COVID-19 was the third leading cause of death in the U.S. In May, the recorded number of deaths due to COVID-19 reached an unprecedented 1 million in the U.S. In June 2022, the ACIP recommended the Pfizer-BioNTech vaccine and Moderna for everyone six months and older. Furthermore, in July 2022, the FDA fully approved the Pfizer-BioNTech vaccine for everyone aged 12-15 (Centers for Disease Control and Prevention, 2022).

The timeline above is based primarily on government sources such as the CDC and focuses on vaccine recommendations. At its core, public health aims to promote and protect the population's health. Mandates that are aimed at protecting public health are ethically justified. Nevertheless, they are justified to the extent that they create a favorable risk/benefit ratio concerning the public good. They also have to be appropriately balanced with limitations on personal autonomy (we will cover this later in the paper). Public health mandates involve coordinated action by government regulatory bodies (Ponesse, 2021).

However, comprehending the ramifications of vaccine mandates is important to understand the definition of both "vaccine" and "vaccine mandate" to understand the topic better. A vaccine mandate requires someone to be vaccinated against a particular disease to take a specific action covered by the mandate, such as attending school, working, traveling, etc. If a mandate is adopted, it means the government or another authority that enacted the mandate may legally prevent someone from entering their building or accessing their services (Benisek, 2022).

Vaccine mandates have been in the news recently because of COVID-19, but vaccine mandates have been around since the 19th century when it was necessary to be vaccinated against smallpox. Today, all 50 states have requirements for kids attending school; states require kids from

birth to age 18 to be vaccinated against polio, measles, meningitis, and many other diseases so they can attend school. States can decide which vaccines are “mandatory” to attend school, though medical exemptions are allowed, and some states even allow for religious exemptions (Benisek, 2022).

The federal government has yet to enact a nationwide mandate, but state governments have historically mandated vaccines. However, with a legally adopted mandate, the government and authorities cannot force an individual to get vaccinated. However, they can withhold services and access, such as attending school or going to concerts and other public places, or even prevent the ability to travel or hold a job. Furthermore, private companies have also utilized their authority to decide whether they want to enact mandates for their employees and even those trying to access or use their services and enter their business (Benisek, 2022).

Given the number of vaccine mandates already in existence, it was no surprise that a wide variety of vaccine mandates related to COVID-19 would be proposed and put in place. While the Supreme Court recently blocked President Biden's sweeping vaccine mandate for larger companies comprising 100+ employees, several COVID-19 vaccine mandates remain in place. There is a federal COVID-19 mandate for healthcare workers employed at facilities that participate in Medicare or Medicaid, and there were mandates for all Federal employees and those in the military. At the state level, 19 states have vaccine mandates for state employees (Roth, 2021). Likewise, many private companies have also mandated COVID-19 vaccines among their workforces. However, 15 states have passed legislation prohibiting or requiring special exemptions before employers can force vaccine mandates on their employees (Roth, 2021).

Ironically, even the term vaccine has evolved over the years. According to the CDC, from 2007-2021, the definition of a vaccine was "a product that stimulates a person's immune system to

produce immunity to a specific disease, protecting the person from the disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the nose" (WHO, 2015). In 2021; the CDC changed the definition of a vaccine to "a preparation that is used to stimulate the body's immune response against disease. Vaccines are administered through needle injections, but some can be administered by mouth or sprayed into the nose" (CDC, 2021). The underlying difference in these definitions is the focus on the vaccine's efficacy. The earlier definition implied that a vaccine provided immunity to a disease. In other words, it prevented a person from getting and spreading the disease to others. The latter definition is much more open-ended and covers anything that causes an immune response to a disease. Nevertheless, more importantly, this last definition does not require a vaccine to prevent someone from actually contracting the disease or being able to spread the disease. This is a major change from the long-held definition of vaccines having to provide immunity to disease.

Vaccine efficacy and safety

The COVID-19 vaccines were first introduced in 2020. Knowing what we do today (and are continuing to learn) about the safety and efficacy of the vaccines, would that change the position of some of the ethical arguments made concerning vaccine mandates? To help determine if the vaccine mandates were ethical, we need to look closely at the vaccines themselves and their overall safety and effectiveness.

In a perfect world, or in many textbook examples of ethical arguments, the vaccines would be considered effective if they prevented disease and were at least safe relative to the alternative of not taking the vaccine. Moreover, that was the basic assumption when the COVID-19 vaccines were originally released. However, we do not live in a perfect world, and the original vaccine

assumptions were incorrect. The issue is a lot more nuanced than most people were led to believe when the vaccines were first introduced. Would these issues lead to a different conclusion on whether the vaccine mandates were ethical, and under what circumstances would the position change?

Due to the emergency situation created by COVID-19, when the vaccines were first rolled out to the general population, the human trials were not even completed at that point. Furthermore, much of the scientific value of the human trials were destroyed by unblinding the trials and offering the real injection to everyone in the placebo groups. Pfizer's trial data showed their vaccine was not as safe or effective as the FDA, CDC, and politicians portrayed (*5.3.6 CUMULATIVE ANALYSIS*, 2021). We know this because the FDA was sued under the Freedom of Information Act (FIOA) by a group of scientists requesting the federal government share the data it relied upon in licensing Pfizer's COVID-19 vaccine, which the FDA attempted to keep sealed for 55 years; the Pfizer data is now being released at a rate of 55,000 pages per month (Greene, 2021). The material released thus far suggests that Pfizer misrepresented data showing major risks as being of no concern, hid serious injuries, and falsely categorized almost all of them as unrelated to the shot without further investigation (*Pfizer Vaccine Trial Fraud*, 2023). For example, a preliminary analysis of Pfizer's Phase 3 clinical trial showed an increased risk for cardiac problems. This is consistent with data from the U.K. During 2021, U.K. ambulance services recorded an extra 27,800 cardiac arrest calls, which was above the national average in previous years, and these calls were among the young (Bermingham, 2023).

Pfizer's trial also found no statistically significant reduction in serious illness or COVID-19 mortality from the injection over six months, which was the length of the trial (Huber, 2022). The risk of serious COVID-19 infection in the placebo group was only 0.04% (which proves just

how low the risk of serious illness was in the first place), yet despite this low risk of serious infection, the regions selected for the trial were chosen for their perceived high prevalence of infection (Huber, 2022). There were two COVID-19 deaths in the placebo group as compared to one death of COVID-19 in the injected group; however, all-cause mortality, which would include complications due to the vaccines, over a longer period of time revealed 19 deaths in the injected group as compared to the 17 deaths in the placebo group (Huber, 2022). Over time the vaccines did not provide any benefit in lowering the overall death rate and possibly increased deaths in the vaccinated group compared to those that were unvaccinated. So certainly, there was no benefit to the vaccine, and the limited data suggest a potential downside.

The Pfizer and Moderna vaccines were associated with an excess risk of serious adverse events of special interest in about one in every 565 people. Dr. Joseph Fraiman (2022), an emergency physician based in Louisiana and lead author of a peer-reviewed study that re-examined the original Pfizer and Moderna clinical trials for the vaccines, said, “That is quite a high number of serious adverse effects from a vaccine. We typically have withdrawn vaccines for one in 10,000” (Fraiman et al., 2022). In other words, vaccines with a serious adverse rate of 1 in 10,000 are usually pulled from the market. For example, the swine flu vaccination program ended in March of 1977 after only a “small number” of people developed Guillain-Barré syndrome (*Gerald R. Ford Presidential Library and Museum*). Dr, Fraiman also noted that the data from the trials showed a great imbalance among vaccinated people, meaning that more testing and monitoring was done on the unvaccinated than on the vaccinated. So, it does not mean that the vaccines do not work; it just means that their efficacy is about 70-80% rather than the 95% claimed (Fraiman et al., 2022). This is a much greater chance of contracting and spreading COVID-19 than initially

reported, and this efficacy wanes significantly over time, which makes booster shots a continued requirement.

In addition, vaccine-associated enhanced disease (VAED) is also listed as an important potential risk, and as of February 28, 2021, Pfizer had 138 cases of suspected VAED, 75 of which were severe and resulted in hospitalization, 38 were lethal cases, and 65 remained unresolved (*5.3.6 CUMULATIVE ANALYSIS*, 2021). The Phase 3 clinical trials are designed to uncover frequent or severe side effects before a vaccine is approved for use, but none of the vaccines have fully completed Phase 3 trials; Pfizer's Phase 3 trial is not due to be completed until 2024 (*Study to Describe the Safety*)!

The warning label on the Pfizer vaccine also makes for some interesting reading. The CDC recommends the shot for pregnant women. However, the Comirnaty label on the Pfizer vaccine states that "available data on Comirnaty administered to pregnant women are insufficient to inform vaccine associated risks in pregnancy" (Nass, 2022). The CDC and FDA contend that the COVID-19 vaccines cannot cause cancer or infertility. However, the Comirnaty label says, "Comirnaty has not been evaluated for the potential to cause carcinogenicity, genotoxicity, or impairment of male fertility" (Nass, 2022). If it has not been evaluated, how can they claim to know it cannot cause those problems?

Part of the justification for the vaccines and mandates was to protect others. Nevertheless, Janine Small, president of international markets at Pfizer, told the European Parliament in October of 2022 that Pfizer did not know whether its COVID-19 vaccine prevented transmission of the virus before it entered the market in December 2020 because the transmission was never studied. However, later, a peer-reviewed study published in the Lancet of 162 Delta-infected index cases and their 231 household contacts—who were tracked and tested every day for up to 20 days,

regardless of symptoms—found that once infected, the vaccinated were just as likely to transmit COVID-19 to people in their households as the unvaccinated: about a quarter of both did so (Singanayagam et al., 2021). They also found that the asymptomatic infection rate among vaccinated and unvaccinated participants was similar: around 30 percent. Dr. Bose Ravenel, a retired pediatrician based in North Carolina who spent 31 years in private practice, 11 years as an academic pediatrician, and six years practicing integrative pediatric medicine, summed it up best when he said, "These mRNA vaccines fail to achieve the foundational function of a vaccine of stopping infection or transmission to others" (Brown, 2021).

We have also seen a surge in sudden age-inappropriate deaths in at least 30 countries in the industrialized world. Dr. Ed Dowd, cardiologist and author of the book "Cause Unknown': The Epidemic of Sudden Deaths in 2021 and 2022," argues that the sudden deaths in young people are due to the mRNA vaccines (Dowd, 2022). He states that the number of excess deaths in the U.S. attributed to COVID-19 in 2020 was less than the huge spike in deaths in 2021 after the vaccines were rolled out; most of those deaths occurred in people aged 18-64, and it was not due to COVID-19 (Dowd, 2022). As of February 4, nearly 34,580 deaths have been reported to the CDC via the government's Vaccine Adverse Event Reporting System (VAERS). The deaths reported for all vaccines combined was 420 in 2020 (before the COVID-19 vaccines were released) and jumped to 22,278 deaths in 2021 (with COVID-19 vaccination), which is a 5,304% increase (Dowd, 2022).

Dr. Aseem Malhotra, a cardiologist and originally a strong proponent of the COVID-19 vaccines and boosters, said that the most common side effect reported regarding the vaccines is myocarditis, which is the inflammation of the heart, and this is prevalent among young people. With the recent studies about the vaccines and his dad suffering injuries from the vaccine and dying, Dr. Malhotra has since changed his stance. Dr. Malhotra calls for the immediate suspension

of the shots. Myocarditis is considered to be permanently debilitating and life-shortening. There is no replacement mechanism for dead cardiomyocytes (cells that pump the heart) (Malhotra, 2022). A pediatric consent form for the COVID-19 vaccines lists several possible side effects, including a myocarditis rate of 10 in 100,000 — far greater than the 1 in 50,000 (i.e., 2 in 100,000) rate previously reported. However, myocarditis is far more frequent in young males, so the risk is significantly higher than 10 in 100,000, as they make up the bulk of these injuries (Malhotra, 2022). Data from Israel shows myocarditis post-vaccination occurring at 1 in 6,000, while in Hong Kong, data from male children and teens found a rate of 1 in 2,700. Health information from the British Yellow Card system shows that 1 in 120 people who received at least one mRNA injection suffered an adverse event beyond mild (Malhotra, 2022). Malhotra also cites a recent study coauthored by some of the most trusted medical scientists in the world concerning data transparency: "Researchers looking at data from the FDA, Health Canada, and the Pfizer and Moderna trials concluded the absolute risk of a serious adverse event from the mRNA shots was 1 in 800, which massively exceeds the risk of COVID-19 hospitalization found in randomized controlled trials" (Malhotra, 2022).

Finally, according to Dr. Colleen Huber, a naturopathic doctor in Arizona who has served as a medical expert witness regarding vaccine injury and vaccine safety considerations in court cases, the COVID-19 vaccines have a negative efficacy because the fully vaccinated are experiencing Antibody-Dependent Enhancement (ADE) and vaccine-acquired immune-deficiency syndrome. This means the antibodies that the vaccine generates help the virus infect more cells than it would have on its own (Huber, 2022). Thus, the immune systems of vaccinated people have been weakened to the point that they cannot fight the SARS-CoV-2 infection, as well as unvaccinated people (Huber, 2022). Analysis of data from 145 countries shows that the vaccines

cause more COVID-19 cases per million and more COVID-19-associated deaths per million; for example, in the U.S., the results were 38% more cases per million and 31% more deaths per million caused by vaccines (Huber, 2022).

There is still a lot to learn about the COVID-19 vaccines, but we know a lot more today than when they were first introduced at the end of 2020. Today, it is clear that the vaccines do not prevent the transmission of COVID-19. Transmission was never a factor studied with vaccines from the beginning, and later studies have confirmed that the vaccines do not prevent the transmission of COVID-19. The vaccines also do not prevent one from contracting COVID-19; at best, it was hoped that they would reduce the seriousness of the disease. In the worst case, they make COVID-19 more serious through antibody-dependent enhancement or vaccine-associated enhanced disease. In addition, the COVID-19 vaccines are now known to have serious side effects, including death, strokes, blood clots, changes in the menstrual cycle, myocarditis, pericarditis, neurological disorders, infertility among men and women, miscarriages, and many others (Huber, 2022). Based on the excess death data discussed above, it is possible that the vaccines, directly or indirectly, are responsible for more deaths than they are purported to save. Given this difference in understanding and knowledge of the vaccines, I will look at the ethical issue of vaccine mandates from two standpoints: The limited state of knowledge at the time the vaccine was released and the point of view of what we know today.

COVID-19 Mandates

Rules and incentives are two ways to fundamentally motivate people and their behaviors. President Biden called on state and local governments to offer 100$ to get vaccinated. This

incentivized people who did not already take the vaccine or wanted to get it to entice them to get vaccinated. According to research from the University of California, roughly 1/3 of unvaccinated people said a cash payment would make them more likely to get vaccinated, so, for example, states like New Mexico, Ohio, and Colorado used the 100$ incentive to get their citizens vaccinated (*FACT SHEET, 2021)*. While many companies offered incentives and communities offered cash or chances to enter into lotteries to get vaccinated, it was not enough. The alternative is rules or mandates. We do these with most vaccinations, like childhood vaccines; one must have these shots to go to school. This is typically done because the vaccination decision affects the individual and everyone else around them.

On September 21, 2021, President Biden signed Executive Order 14043 mandating that federal employees and contractors (Executive Order 14042) be fully vaccinated against COVID-19 (*Executive Order 14042*, 2021). Federal employees had to attest their vaccination status. If they did not get vaccinated, federal employees were to wear a mask on the job no matter their geographic location, physically distance from all others, comply with 1-2 times a week COVID-19 testing, and be subject to restrictions on business travel (*FACT SHEET, 2021)*. This guidance was later changed, and by November of that year, agencies told employees that those who did not get vaccinated were to receive education, counseling, and a reprimand. If that failed to persuade the employees, then actions to remove the employee were to be undertaken. What started as a way to make work-life harder for federal employees who did not take the vaccine quickly morphed into President Biden giving federal employees two options, get fully vaccinated or lose their job. The case for federal contractors was similar though the contractors had more discretion in forcing vaccination, firing employees, or just following the additional testing and other requirements. In January 2022, a federal appeals court placed an injunction on both Executive Orders while hearing

a case to determine whether the Executive Orders on vaccine mandates were unconstitutional. The case is still in the courts and has not been resolved.

Military personnel were also forced to get the COVID-19 vaccine, as they are normally required to get all sorts of shots and vaccines. However, at least 8,000 frontline troops refused and were involuntarily separated from service (Ramchand et al., 2022). Another 60,000 army soldiers have lost pay and benefits over vaccine mandates, including 40,000 National Guard and 22,000 Reservists soldiers who have refused the vaccine (Blankley, 2022). This amounts to 13% of the Army Guard and 12% of the Reserve when the military falls well below-desired recruitment levels. In other words, many thousands of military personnel lost their jobs for not getting vaccinated with an experimental drug. While too late for many, the Secretary of Defense, Lloyd Austin, officially rescinded the military's COVID-19 vaccination mandate for troops after President Joe Biden signed the 2023 National Defense Authorization Act, requiring its dismissal in January of 2023 (Britzky, 2023).

COVID-19 mandates were also incorporated by nearly every postsecondary school in the country. Even today, over 1,000 colleges and universities across the United States (including private, religious, and state schools) require students to be vaccinated for COVID-19 to participate in on-campus instruction (Johnson, 2021). The University of Akron also had such a mandate for some time but quickly and quietly dropped it as many students refused to participate. Later, the State of Ohio passed a law prohibiting COVID-19 vaccination mandates for public schools. Currently, according to the University of Akron website: "Beginning with the fall semester 2022, COVID-19 vaccines, including all booster shots, are strongly recommended for our entire University of Akron community **but are no longer required** for (some or many) students" (Ohio).

By the end of 2021, 85% of American adults had received at least one dose of the vaccine; those unvaccinated chose to remain so, even with vaccine mandates covering much of the population, because they were worried about side effects from the vaccines (US Census Bureau, 2021). Furthermore, many who took the vaccine felt unfairly coerced because of mandates. In September of 2021, President Biden required federal employees and contractors to the federal government get vaccinated. In November of that year, the Occupational Safety and Health Administration (OSHA) announced a requirement for employers with 100 or more employees to ensure each of their workers is fully vaccinated or tested for COVID-19 on at least a weekly basis (The White House, 2021). In addition, the Centers for Medicare & Medicaid Services (CMS) at the Department of Health and Human Services announced a requirement that healthcare workers at facilities participating in Medicare and Medicaid be fully vaccinated. These federal mandates, implemented by the President and the executive branch, affected nearly 100 million Americans. States, cities, and private companies covered much of the population (The White House, 2021).

Because of COVID-19 mandates, tens of thousands of people lost their jobs and livelihoods, could not attend school, or had other opportunities terminated. Many millions of others were coerced to receive an experimental vaccination, with unproven safety and efficacy when it was released, rather than become unemployed or quit schooling in the middle of their education. The ethical considerations of such mandates are discussed in the next section.

Ethical Theories

The first ethical theory we will look at is Utilitarianism (I am using the version of this theory that people use to justify vaccine mandates). It determines right and wrong by focusing on the outcomes and is a form of consequentialism. Jeremy Bentham founded this theory; he and John

Stuart Mill were classical utilitarians. They were concerned with legal and social reform, and the desire for the ethical theory was to see useless, corrupt laws and social practices changed (Driver, 2014). For Jeremy Bentham, some laws were bad, which resulted in an analysis as to why they were bad, and what made them bad was their lack of utility (their tendency to lead to unhappiness); "if a law or action doesn't do any good, then it isn't any good" (Driver, 2014). The core insight behind the theory is that morally appropriate behavior will not harm others, but it will instead increase utility, also known as happiness, benefits, or pleasure (Santa Clara University, 2014). It is a moral principle that says the morally right thing to do in any situation is the one that produces the greatest balance of benefits over harms for everyone involved. This means a course of action should produce the maximum benefits for everyone, even if the motivation behind the action is produced by lies, manipulation, or coercion (Santa Clara University, 2014). In other words, the most ethical choice will produce the greatest good for the greatest number. The "good" holds the same value for everyone, meaning one person's happiness is in no way more important than another's happiness, and maximizing the good means that as a result of the action, the net good in the world has increased. An act may not be morally right even if it promotes happiness for many if it requires a great sacrifice from some unless the act produces more net happiness than any other act. Legislators, scientists, and business analysts use this theory daily when weighing the results of their actions or policies, for example, whether to invest resources in a certain public project, whether to approve a new vaccine or drug, whether to ban a certain pesticide, or whether to implement a mandate (Santa Clara University, 2014). Utilitarians would require any level of sacrifice, provided the sum of those sacrifices is smaller than the collective benefits.

Utilitarianism offers a straightforward method for deciding the morally right course of action for any situation we find ourselves in. First, identify the various courses of actions that we

could perform. Second, determine all the foreseeable benefits and harms that would result from each course of action for everyone impacted by that action. And third, choose the course of action that provides the greatest benefits after weighing the costs (Santa Clara University, 2014).

There are limitations to this theory. In the eyes of a utilitarian, people are looked at as being homogenous and interchangeable. We cannot predict the future, so it is difficult to know with certainty whether the consequences of our actions will maximize utility or bring about pain. Utilitarianism has trouble considering the values of justice and individual rights; for example, a hospital has four people whose lives depend upon receiving organ transplants: lungs, a heart, a kidney, and a liver (The University of Texas at Austin, 2023). If a healthy person wanders into the hospital, his organs could be collected to save the lives of four people, but in return, he would lose his life. Taking his organs would produce the greatest good for the greatest number of people. Is sacrificing one life to save four the right thing to do? Some people think doing so is not an acceptable course of action nor the most ethical one, but most utilitarians think it is the most ethical thing to do (The University of Texas at Austin, 2023). This means that we are using people as mere means, which may lead to sacrificing lives for the greater good (Sirotkin, 2014). Utilitarians justify punishing an innocent party if necessary to bring about an important good consequence. The happiness which forms the utilitarian standard does not mean our happiness but everyone else's happiness (Sirotkin, 2014). The decision-making method of this theory is often very time-consuming and leaves little time for promoting happiness.

Let's look at mandating the COVID-19 vaccine through this theory, but first, let us discuss vaccine mandates in general as if the COVID-19 vaccines are like normal vaccines. According to a Utilitarian, a vaccine mandate is ethical because they maximize utility. A vaccine protects against diseases and prevents serious illnesses not only for the person who got it, but vaccines also protect

other people who did not get vaccinated or can't get vaccinated. Vaccines help to achieve herd immunity, and herd immunity, in this case, is "utility." One must get vaccinated to prevent harm, which is dying or getting sick from the disease. By getting vaccinated, you are maximizing the benefit (herd immunity) and minimizing the pain (dying or getting seriously ill from the disease). Getting vaccinated protects not only you, your family, and your community but also those most vulnerable around us, those with underlying health conditions or immunocompromised. Even if the vaccine has some side effects, it is still morally right to get vaccinated because the vaccine's benefit outweighs its harm (side effects). By getting vaccinated, you are increasing the "happiness" of the world by allowing people to live life because herd immunity has been achieved; not as many people will die or suffer at the hands of the disease. A utilitarian believes that you should make sacrifices, though the level of sacrifice can vary buy the if it means producing the greatest good for the greatest number of people. Still, this sacrifice has to be smaller than the collective benefit it brings about. By getting vaccinated, you are sacrificing yourself by experiencing side effects so that herd immunity can be achieved so that the spread of the disease becomes very unlikely and no one else has to die or get sick. The outcome of getting vaccinated is a positive outcome for everyone in society; therefore, it is the morally right thing to do, even if it means making someone get vaccinated; it does not matter how the outcome is accomplished as long as the outcome maximizes the greatest good for the greatest number of people. Dr. Fauci best summarizes a utilitarian approach to vaccine mandates:

> When you get vaccinated, you not only protect your own health and that of the family but also you contribute to the community health by preventing the spread of the virus throughout the community. In other words, you become a dead end to the virus. When there are a lot of dead ends around, the virus is not going to go anywhere. That is when you get

a point that you have a markedly diminished rate of infection in the community (Choi, 2021).

Let us now take a look at the COVID-19 vaccine mandates. As stated earlier, the vaccine efficacy is about 70-80%. This means that the vaccines are only about 70-80% effective in preventing serious illness or mortality from COVID-19 compared to the 95% we were led to believe. The COVID-19 vaccines cause a slew of serious adverse effects, including death. We were lied to by government officials to get vaccinated; they claimed, lied, and coerced us so that we could be vaccinated to maximize the greatest good for the greatest number of people. Their intentions were immoral, but the consequence was meant to produce the greatest good for the greatest number of people. The government and everyone else who mandated the vaccine took the utilitarian approach. They wanted to maximize the greatest good (herd immunity and a return to normal) and minimize harm (serious illness or death from COVID-19). However, a utilitarian approach "supports a moral obligation to be vaccinated, unless the individual cost of being vaccinated would be so great as to outweigh the expected negative contribution of non-vaccination to the aggregate wellbeing of others" (Kaminer, 2021). This means vaccination is unethical if the harm of being or getting vaccinated is worse than getting COVID-19. As stated earlier, the vaccines cause serious heart issues, which frequently lead to death among perfectly healthy young people, worse than those suffering from COVID-19. Most healthy people who got COVID-19 experienced fevers, body aches, cough, loss of taste or smell, sore throat, and difficulty breathing.

In comparison, one is safer from COVID symptoms than myocarditis, which healthy young people obtain from the vaccine. In this case, mandating the vaccine would be unethical, even in the eyes of a utilitarian. The sacrifice of getting the vaccine is not smaller than the collective benefit of herd immunity. As stated earlier in the paper, the huge spike in deaths in 2021 was not due to

COVID-19 but due to the vaccines. The vaccines also do not prevent infection nor stop the transmission of COVID-19. By having serious adverse effects, not preventing COVID-19 infection, nor stopping transmission of COVID-19, the benefits of the vaccine (70-80% effective at most) do not outweigh the harm. Granted, at the beginning of the pandemic and even at the end of 2020, there was not a lot of data or information on the vaccines; top officials and businesses did what they thought was morally right by mandating the vaccines. They wanted to maximize the greatest benefit (herd immunity and return to normal) and minimize harm (serious illness and death from COVID-19). But even after data, information, and studies on the vaccines concluded they are not safe, effective, or tested properly, government officials and businesses still mandated them.

In the example above about the organ transplant, taking the organs of a healthy person to help four people in need is producing the greatest good for the greatest number of people, even though you are sacrificing one person's life. In this example, you are using a person as a means to an end. With a normal vaccine, you experience some side-effect such as a fever or a sore arm, but symptoms do not usually last more than 24-48 hours (CDC, 2019). Those symptoms are what you "sacrifice" yourself for in return for protection from disease and for others to be protected. You sacrifice yourself to a fever and sore arm to protect the community from disease and thrive, maximizing happiness or utility. However, that is not the case with this vaccine. When the governments and businesses mandated the vaccine, even when studies showed how it was unsafe and ineffective, they were using people as a means to an end. This is morally acceptable in the eyes of a utilitarian, but the vaccines still cause people who are vaccinated to get COVID-19. On top of that, they suffer serious adverse effects, and vaccinated people can still spread COVID-19 to vaccinated and unvaccinated people. You are using someone as a means to an end while maximizing harm rather than benefit, which is unethical in a utilitarian approach. You can use

someone as a means to maximize the benefit for the greatest number of people, but when you do not maximize the benefit for the greatest number of people, it is unethical.

This leads us to our next theory of Kantian ethics. Immanuel Kant was a German philosopher whose theory was known as deontology. Deontology means obligation or duty, and it is an ethical system primarily concerned with one's duty. Unlike Utilitarianism, the end result is not important; how we get to the end result is important. Kant assesses the morality of one's action and disregards the consequences. He also believed that we have duties that are imperative and that these duties cannot be abandoned regardless of the anticipated outcome; these duties are absolute and have to be applied to everyone equally (McCartney, 2015). There are two types of duties: hypothetical imperatives and categorical imperatives. The hypothetical imperative is a duty necessary to achieve a certain goal; it is something we do to attain an end (McCartney, 2015). The Categorical Imperative (CI) is a duty regardless of the outcome, and the act is unrelated to the end result. An action may be morally wrong even if the result is good. For example, unlike Utilitarianism, lying to someone is morally wrong even if it brings about a good consequence or outcome; everyone has a right not to be lied to, even if the intention was good or not. Kant believes that if you lie and have good intentions with that lie, it is still morally wrong. Intentions do not matter, the act matters.

The categorical imperative is broken down into three categories: the formula of universal law, the humanity formula, and the autonomy formula. The formula of universal law is "act only on that maxim whereby you can at the same time will that it should become a universal law" (Sandel, 2009). By "maxim," Kant means a principle or rule that explains your action. We should act only on the principle that we can universalize without contradiction, and this applies to everyone in the same circumstances without exception. When considering an action, we must ask

ourselves, “Can I consistently will that this same action be done by others when I am at the receiving end of the action” (Campbell, 2017)? This is most familiar to us in the form of the Golden Rule, “Do unto others as you would have done unto you” (Campbell, 2017).

With the humanity and autonomy formula, Kant explains how we should not use people to achieve our desired end result; “always treat people as ends in themselves, never merely as a means to one’s own ends” (Westacott, 2016). According to Kant, humans are moral beings who are free and rational. Treating someone as a means to your purpose is not respecting that they are free and rational. For example, if I get someone to do something by making a false promise or keeping information from someone that would otherwise make someone not do something, I am manipulating them. Their decision to help me is based on false information, and I have undermined their rationality (Westacott, 2016). Treating someone as an end means respecting that they are capable of free rational choices, even if their choices differ from what you want them to make. To get someone to do something, the moral course of action is to explain the situation, explain what choice you want them to make, and let them make their own decision (Westacott, 2016). Kant argues that we are all worthy of respect, not because we own ourselves but because we are rational and capable of reasoning. We are also autonomous and capable of acting and choosing freely (Sandel, 2009). Freedom is not a universal law set in concrete, but it is something of one’s own making. Which means acting virtuously to avoid a fear of being punished is self-defeating. To act freely is to act autonomously; acting autonomously means acting according to a law you give yourself—not according to the dictates of social convention or nature (Sandel, 2009).

Kant’s treating someone as an end, as opposed to a means, is acting in such a way that treats humanity as an end instead of a mere means. Using someone as a mere means involves them in a scheme of action to which “they could not in principle consent” (Sirotkin, 2014). Treating

someone as an end is to respect an individual as a rational being with their own maxims. Humans are free and capable of rational behaviors and should not be used purely for happiness or the enjoyment of others. What is the definition of consent? Consent is "an act of reason and deliberation" that a person who possesses a sufficient mental capacity makes with the recommendation from others (this will come back later) (*Consent*, 2019). If, however, someone agrees to an activity under the pressure of intimidation or threat, then it is not consent because they did not agree to it freely; freely given consent is the consent of the person's own free will, not induced by fraud, coercion, threats of violence, or violence (RAINN, 2019). Consent must be voluntary or it is not consent at all.

That said, let us look into the COVID-19 vaccine mandates. If the vaccines were like those for polio and measles, then the vaccine mandates in the eyes of Kant and fellow Kantians can be viewed as ethical. The ability of individuals to not receive vaccines rests upon the notion of herd immunity. Herd immunity creates a situation that allows people who opt out of vaccinations to use the community around them as a pseudo-vaccine. People who opt out of receiving a vaccine (unless they have a medical exemption) use others as a mere means. Kant does not advocate for people using others as a mere means to an end (Moore, 2017). People not receiving a vaccine due to personal or religious beliefs use their community as a pseudo-vaccine via herd immunity. Herd immunity is provided without consent to both parties, which implies that we should always be treated as ends in themselves and as free autonomous agents (Moore, 2017).

However, it is unethical in this sense: we have to treat people as rational beings capable of reason. Mandating vaccines does not allow people to make their own free choices. By mandating a vaccine, you are not allowing people to act autonomously; you are making them act how you want them to act. This is not treating them as rational human beings who can make rational

decisions. You are using them as a means rather than to an end when you mandate a vaccine. Treating someone as an end means respecting that they are capable of free rational choices, even if they are different from what you want them to make, like not getting a vaccine. Mandating a vaccine is "soft coercion;" to do a specific action or go to a specific place, you must be vaccinated. This is not allowing someone to properly consent to the vaccine because if they do not get it, they cannot do something or go somewhere, which keeps them from acting freely, rationally, and autonomously. The punishment for not getting a vaccine is not being able to go to school or be able to work, and making a decision based on punishment is not acting virtuously. As stated before, it does not matter about the outcome but how one gets to it; acting out of fear of punishment is not acting morally, even if the outcome is good.

The COVID-19 vaccine mandates, with what we know today about them, are unethical, in what I think would be the in eyes of Kant and other Kantians. To be treated as an end and not a means to an end, we must be treated as rational human beings who can make our own choices freely and autonomously without fear of punishment and with proper consent. For us to get vaccinated, government officials withheld key information about the vaccines that would otherwise change the minds of many not to get vaccinated. The FDA tried to keep the trial data of the Pfizer vaccines hidden from the public, claiming it was safe for everyone to get them when in reality, they are not safe. The CDC and the FDA claim that the vaccines are safe for pregnant women, but the Comirnaty label says that the data is insufficient to inform of risks for pregnant women. The government wanted us to do something, which is to get vaccinated, and they presented us with false promises of vaccine efficacy as well as hid relevant and important data about the vaccines, which is manipulation. They lied and made false promises to meet the outcome of herd immunity and to protect people from COVID-19; this is a morally right outcome, but according to

Kant, it is the act that is morally right or wrong, not the outcome. Lying and deceiving the public to get them vaccinated is morally wrong, even if the outcome is good. One should never lie and deceive, even if it is for good. It would be best if you were informed about what you are consenting to, to consent. We were not properly informed about the vaccines, so we could not act rationally regarding our choice to get vaccinated. According to Kant, we are moral beings that are rational and free; we are capable of reason and come to decisions on our own rationally. The government needed to present us with the facts and information about the vaccines and let us make our own decisions on whether we want to get vaccinated; that would be the morally right thing to do.

Mandates do not allow us to consent properly. For example, some businesses mandated the vaccines for their employers. They left their employees with the choice of getting vaccinated or losing their job, and many employees got vaccinated because they did not want to lose their job. The mandate is perfectly legal, but the employees are not deemed rational human beings capable of making their own choice freely. Their punishment for not getting the vaccine was to lose their job, and therefore they got it, but that action was not virtuous. Most people felt they had no other choice but to get the vaccine because it was that or lose their job. That is not voluntary consent. In this one example, the people who got the vaccine did it involuntarily not to lose their job. This can also be applied to schools mandating it. The government and employers used us as a means because they involved us in a scheme of action (getting vaccinated) to which we could not properly consent to. Treating someone as an end and not a means is accepting that we are free and rational to make our own choices, even if the choices differ from yours.

I evaluated two classical ethical theories relevant to vaccine mandates, but now I will discuss an alternative to the classical theories. “Casuistry” focuses on decision-making using particular cases “where judgments reached rely on judgments reached in prior cases” (Beauchamp,

2003). A casuist is skeptical of the power of principles and theories to resolve problems in certain cases. They feel that many forms of moral judgment do not involve appeals to general guidelines but to paradigm cases, precedents recognized by previous cases, and accepted narratives (Beauchamp, 2003). Casuists concentrate their attention on practical decision-making in particular cases and the implications of those cases for others. They proceed by identifying the specific features and problems present in the case. They identify the relevant precedents and prior experiences with related cases to determine how similar and different the present case is from others.

A casuist views moral judgments and recommendations similarly; one can make successful moral judgments of agents, actions, and policies, casuists say, only then one has an intimate understanding of particular situations and an appreciation of treating similar cases similarly (Beauchamp, 2003). Casuists take a bottom-up approach. They look at a case as a starting point rather than a theory and then look for theories or moral principles emerging from the case in consideration by determining what was posited in similar cases (Flynn, 2021). This is essentially a "common-law" approach applied to ethics.

We can apply a casuist view to the COVID-19 vaccine mandates by looking at whether vaccine mandates were applied in the past and the manner and rationale for doing so. There is some historical precedent for mandating vaccines. One precedent is how we dealt with smallpox. The case of Jacobson v. Massachusetts (1905) saw vaccines mandated successfully to fight smallpox. In this case, the United States Supreme Court ruled that the vaccine was justified and did not violate religious freedoms (Ponesse, 2021). Here, the Supreme Court took a utilitarian stance; we must sacrifice our religious freedom to protect the public (maximizing the good while minimizing the negative). Many people today sight that case as why we should mandate the

COVID-19 vaccines. The justification is that we did it in the past for the common good, so the same should hold now.

Dunne and Spain have taken a more detailed casuist view of COVID-19 vaccine mandates (Dunne & Spain, 2022). They explored two cases to ascertain whether it was acceptable to require compulsory vaccination against COVID-19: 1) compulsory vaccination for common childhood diseases such as measles, mumps, rubella, and polio and 2) compulsory treatment for infectious disease. Dunne and Spain came to conclusion that the use of compulsory vaccination for infectious diseases in childhood, such as measles, mumps, rubella, and polio, is not justification for mandating the COVID-19 vaccines (Dunne & Spain, 2022). In their view, relating infectious disease pandemics involving uncommon pathogens was not considered analogous to previous experience with compulsory vaccination against common infectious diseases in childhood. Regarding the COVID-19 vaccination, the authors suggested that "the potential benefits of vaccination for children may be marginal" (Dunne & Spain, 2022). Further, the arguments favoring compulsory adult vaccination against COVID-19 were stronger than those supporting vaccination in childhood. They also considered that "in light of expedited vaccine development, regulatory approvals and reports of adverse event incidence (e.g., myocarditis following mRNA vaccine administration and unusual blood clotting despite low platelets), any such program would require comprehensive pharmacovigilance" and did not justify the mandatory use of the vaccines (Dunne & Spain, 2022). However, in their opinion, the second argument did justify COVID vaccination mandates. While admitting that compulsory treatment is utilized rarely in the context of infectious disease, they claimed that it may be necessary in some circumstances to limit contagion. The precedent that they cited for this was the Model State Emergency Health Powers Act. This act provides for a variety of mandatory measures including physical examination, testing,

treatment, quarantine, and isolation in the event of a bio-terrorist attack or the outbreak of a natural disease. They argue that compulsory treatment is similar to compulsory vaccination in that both involve an invasion of bodily integrity, and therefore, both should be employed in limited circumstances (Gostin et al., 2002). They reasonably argue that compulsory vaccination is generally less invasive than compulsory treatment. In addition, the side effects of vaccinations are generally mild, and serious adverse reactions rare and generally short-lived. In contrast, compulsory treatment is likely to be more invasive and may involve sustained therapeutic management over an extended period with potential for significant impact on the recipient (Gostin et al., 2002). Therefore, if compulsory treatment is considered acceptable in some limited circumstances, it seems reasonable to argue that compulsory vaccination against COVID-19 may also be warranted due to the reduced impact on bodily integrity and the considerable risk of COVID-19.

Since the argument made by Dunne and Spain is based on Model State Emergency Health Powers Act, it is worth exploring this "Act" in more detail, as it was something I was completely unfamiliar with. The Model State Emergency Health Powers Act (MSEHPA) is proposed legislation, driven by the terrorist events of September 11, 2001, for enactment by individual states (not the federal government) to ensure an adequate, coordinated response to public health emergencies, such as naturally occurring epidemics as well as deliberate acts of bioterrorism (Laggy, 2004). This "Model Act" was drafted by the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities at the request of the Centers for Disease Control and Prevention and led by Lawrence O. Gostin and seven others (Gostin et al., 2002). The Model Act discusses the special powers a public health authority may exercise during an emergency. These are grouped under three broad categories (Mishel, 2019). There are "Reporting Provisions" that

define the conditions and duties of healthcare workers to collect and report potential health emergencies and corresponding data to the respective authorities, "Declaration Provisions" that give state governors nearly exclusive authority to decide the timing and duration of a state of emergency; and the "Medical Treatment Provision," that allows for medical examination, testing, vaccination, treatment, isolation, and quarantine of persons, under conditions that are not "reasonably likely to lead to serious harm to the affected individuals" (Mishel, 2019).

This last provision is the basis for Dunne and Spain's casuist argument for mandatory COVID-19 vaccines. However, while 40 states have incorporated some components of the Model Act, as of 2011, only 19 have adopted the Medical Treatment Provision, and Gostin and the Model Act's coauthors defended the Medical Treatment Provision by arguing that the restraint of individual liberty in extreme situations is justified by the need to protect the common good and the welfare of the public by pointing to enforced conduct such as vaccination of school children and the wearing of seat belts in vehicles as being a part of public health law (Gostin, 2003).

Sadly, the precedent of the Model Act cited by Dunne and Spain to justify their casuist argument could be stronger and more consistent with their previous arguments. The provision of the Model Act that has to do with forced treatment, and thus justifying forced vaccination, has only been accepted by a minority of states, so it is not a major precedent. Furthermore, the authors of the Model Act justify the use of forced treatment by citing the forced vaccination of school children. But Dunne and Spain have already declared that forced vaccination of school children does not justify mandatory COVID-19 vaccines and certainly not mandatory treatments; therefore, they have negated their own argument.

So even assuming an ideal safe and effective COVID-19 vaccine, I could not find a rational casuist argument to support vaccine mandates. Furthermore, what we know now about COVID-

19 and the COVID-19 vaccines would weaken any argument further. The smallpox virus, referred to in the original casuist argument above, and the COVID-19 virus are vastly different (Ponesse, 2021). The vaccines for smallpox, measles, mumps, rubella, and polio are vastly different. Smallpox is virulent, with an infection fatality rate over thirty times greater than COVID-19. The average age of death for smallpox was very young people, kids one to five- and middle-aged people, whereas COVID-19's average death exceeded the national life expectancy. The smallpox vaccine (and the vaccines for measles, mumps, rubella, and polio) are sterilizing (meaning the vaccine completely prevents the disease) (Ponesse, 2021). In contrast, the COVID-19 vaccine is leaky, meaning people with it can still get COVID-19 and spread it. In addition, the side effects of the COVID-19 vaccine may be more severe and lead to a greater number of excess deaths than the virus itself, as we have previously discussed.

Meeting the Ethical Threshold

The mere existence of a vaccine to counter a certain virus does not allow us to assume that it should be mandated. The following considerations explore some of the nuances of this issue. They are crucial for determining when the threshold has been met to justify ethically mandating a vaccine such as those developed for COVID-19.

The first aspect for consideration concerns how dangerous and deadly the original disease is. There has to be a significant morbidity and mortality rate from the disease for which the vaccine is being mandated. For a vaccine mandate to be ethical, the disease in question must be a highly virulent pathogen that causes significant mortality and morbidity. The virus must pose a substantial threat to everyone (Ponesse, 2021). For example, the mortality rate of smallpox is thirty percent, and the infection fatality rate of Ebola is fifty percent. COVID-19, by contrast, only has an

infection fatality rate of 0.05% for a healthy person under seventy years old, which is the same rate of mortality as that for influenza, and yet yearly flu shots are optional and not mandated for the general population (Baker & Wilson, 2020). Most people who got COVID-19 experienced relatively mild cold-like symptoms. Compared to smallpox and Ebola, COVID-19 is not a highly virulent pathogen. Under this criterion, it does not meet the threshold for morbidity and mortality to justify a vaccine mandate ethically (Ponesse, 2021).

To mandate a vaccine, there must be no other effective treatment options for the disease. This is not the case with COVID-19. McCullough and colleagues have developed a very successful sequenced multidrug therapy (SMDT) for treating COVID-19 (McCullough et al., 2020). It consists of a multipronged therapeutic approach beginning early in the ambulatory period with available medications, including anti-infectives (hydroxychloroquine, ivermectin, azithromycin, doxycycline), corticosteroids, and anti-platelet drugs and anticoagulants (McCullough, 2020). The three dimensions of the COVID-19 infection and their time course allow for this sequenced multidrug approach to be utilized to reduce hospitalization and death. Some of these treatments have been unfairly criticized in the U.S. press in favor of vaccines (McCullough et al., 2020). But when combined in a meaningful SMDT approach, this treatment regime is "responsible for saving hundreds of thousands of lives and sparing millions of hospitalizations" (McCullough & Vijay, 2021). In addition, effective treatment options like ivermectin were offered as an early home-based treatment in at least seven countries, hydroxychloroquine was a primary treatment in 18 countries, and additional drugs, vitamins, and minerals such as azithromycin, fluvoxamine, Vitamin D3, zinc, and quercetin have also been used effectively throughout the world to treat COVID-19 (Huber, 2022). Ronald Derwand and his colleagues suggest that these available drugs used in combination can reduce hospitalizations and death by 85% in high-risk patients (Derwand et al., 2020). High-

risk patients are those considered over age 50 and or those with one or more comorbidities (obesity, diabetes mellitus, heart disease, pulmonary disorders, renal disease, and malignancies). And the good news is that most healthy individuals with COVID-19 under 50 years have a self-limited illness, and no specific treatment is advised in the absence of severe symptoms (McCullough, 2020). Again, this would not justify mandating experimental vaccines on nearly the entire population.

Justifying a vaccine mandate depends largely on how effective a vaccine is. How sterilizing or non-sterilizing a vaccine should be crucial to determining the ethical justification of a vaccine mandate. Vaccine mandates are generally put in place if the vaccines prevent the transmission of a pathogen and protect against the pathogen. A vaccine that operates in this manner would be defined as a sterilizing vaccine, such as those developed for polio, smallpox, mumps, and rubella. But the COVID-19 vaccines, as stated earlier in the paper, do not prevent transmission of COVID-19 nor protect against catching the disease. COVID-19-vaccinated people can still become infected with and transmit the virus. A recent paper published by Anthony Fauci readily admits that because viruses like the SARS-CoV-2 (which cause COVID-19) generally do not elicit complete and durable protective immunity by themselves, they have not been effectively controlled by licensed or experimental vaccines (Morens et al., 2023). It is unclear why there was an emphasis on COVID-19 vaccines, as they are non-sterilizing.

The ethical justification of a vaccine mandate also depends on the risks and benefits of the virus versus the vaccine. The risks of the disease must be balanced against the risk of being vaccinated. As I talked about earlier in the Utilitarian section, mandating the vaccine is justified when the vaccine's benefits are high because of vaccine efficacy and the health risks from the vaccine are low. But this is not the case with the COVID-19 vaccines. The COVID-19 virus has a

low infection fatality rate, the vaccines for COVID-19 are non-sterilizing or leaky, and there is an unprecedented number of serious adverse reactions to the vaccines including death, myocarditis, blood clots, strokes, etc. Going back to the Utilitarian theory, the harm does not outweigh the benefit, and the COVID-19 vaccines are not ethically justified in this category (Ponesse, 2021).

Related to the concept above, the next threshold is the disproportionate harm of vaccines. A vaccine mandate can be ethically justified as long as the vaccine does not harm people more than it provides safety by preventing or reducing the severity of illness. David Healey, a psychiatrist and psychopharmacologist said, "A core feature of healthcare is that a medicine should not produce disproportionate problems; a sleeping pill should not cause peripheral neuropathy or congenital disabilities" (Ponesse, 2021). The COVID-19 vaccines are showing themselves to produce unnecessary problems. As stated earlier in this paper, the vaccines are causing death among healthy young individuals who would not otherwise die from COVID-19. Since the vaccine rollout, excess deaths in the US have largely been attributed to the vaccines rather than the virus itself (Huber, 2022). People aged 24-35 are more vulnerable to disproportionate harms from the vaccine than someone in their 60s; one could argue that mandating it, especially for the younger generations, is unethical since they have the most to lose if affected by vaccine injury. They are starting their careers and lives, may have young families to support, or are planning on starting a family. This means the COVID-19 vaccine mandates will be potentially more harmful and less justified as we work our way down the age groups (Ponesse, 2021).

The last threshold is risk assessment. People vary widely in how they assess risk regarding healthcare decisions. Risk averseness depends on many different factors like age, gender, personality, life plans, the existence of a family and other relationships, past experiences, and health status. For instance, someone with end-stage cancer may be willing to participate in a cancer

drug trial with unknown or even severe side effects. But someone with a young family may be less likely to take on risks that threaten their employment status. Applying a rule that makes all of us behave in the same way (assuming the same level of risk) is a further affront to personal autonomy; it is ethically unjustified, and on top of that, it is likely to generate reasonable resistance (Ponesse, 2021).

The second aspect of consideration for mandating the COVID-19 vaccines poses a unique ethical challenge to authority and legitimacy. To what extent can the federal government, states, and private entities implement measures that protect public health? What if these measures violate our personal freedoms? What makes public health 'public' is that it is the business of public institutions and not just private individuals or entities. Understanding who and what those public institutions are and how they affect the health of populations is important in determining whether those actions are effective or harmful. If we assume, in a perfect and functional democracy, that action by the government is action by the people, then the interests of the government and the people should be aligned. The physical and mental well-being of the population should be the morally responsible public health policy (Ponesse, 2021). But in practice, the interests of public institutions and legislating bodies do not always align with the public interest. For example, Moderna recently paid the National Institute of Allergy and Infectious Diseases (NIAID), directed until very recently by Anthony Fauci, a $400 million "catch-up payment" under a new royalty-bearing license agreement between the two parties related to the recent mRNA vaccine they developed to fight COVID-19 (Sagonowsky, 2023). Generally, when royalty payments are made to the government, a significant amount is paid to the government employees involved in developing whatever technology the government licenses. While NIAD has not defined how this royalty will be dispersed, it certainly leads to a possible conflict of interest between the government

and how vaccine mandates have been pursued. Based on recent Freedom of Information Act Requests (FOIA), between 2009 and 2014, Anthony Fauci received 23 royalty payments, Francis Collins, the director of NIH, received 14 royalty payments, and Clifford Lane, Fauci's deputy at NIAID, received eight payments from various pharmaceutical companies (Smith, 2022). Although the number of payments to each scientist is known, how much money was paid is unknown because the data was redacted from the FOIA disclosures. Also, payments made after 2014 should have been disclosed during the most recent release of documents (Sagonowsky, 2023). So, while it is not clear whether a direct conflict of interest occurred during COVID-19, the threshold should not be an appearance of a conflict of interest, which is certainly not the case here. In this case, the appearance of a conflict of interest raises serious questions about the legitimacy of the vaccine mandates pushed by Fauci, Collins, and others in the federal government.

The link between federal officials and the pharmaceutical companies, where royalty payments have been and continue to be made, complicates the approach to evaluating risks associated with the vaccines. Ethically compromised government officials at the CDC and elsewhere continue to assure us that “COVID-19 vaccines are safe and effective” (CDC, 2020). But an important ethical consideration for the vaccine mandates relates to the fact that they are still in their Phase 3 clinical trials. The vaccines are authorized for emergency use; this means they are naturally investigational, and the people who received the COVID-19 vaccines are participating in an ongoing research trial. Ethically, an investigative vaccine should never be mandated because of the inherent risks of pharmaceutical trial participation. Since unknowns about safety and efficacy enhance risks and undermine autonomous medical decision-making, people cannot give true informed consent (Ponesse, 2021). Fully informed consent about the COVID-19 vaccines will not

be possible. It probably won't be possible for a very long time until many of the long-term side effects from the vaccines are fully realized and better understood.

Next, we look at the integrity process. The information must be transparent to secure the best outcome in public health. In an ideal world, there would be no conflicts of interest; there would be an effective uptake of information at the patient level to assess the vaccine's safety and efficacy. The capacity for an individual to consent to the COVID-19 vaccines relies largely on the integrity of the trial process. Without that, it is hard to imagine how anyone could give full and informed consent (Ponesse, 2021). As noted earlier in the paper, Pfizer and the FDA misled, covered up, and tried to block access to important data and information about the vaccine trials that are only now becoming public under FOIA mandates. That is the definition of undermined integrity. If the vaccines were perfectly safe and effective, why was so much emphasis placed on hiding the data as opposed to explaining the data to the public in full and honest disclosure? In the case of the COVID-19 vaccines, there is a complete lack of integrity around the pharmaceutical companies hiding data from the government employees receiving royalties, who had no problem with the lack of transparency and insisted, without proof beyond a reasonable doubt, that new experimental vaccines that have not even completed Phase 3 trials are perfectly safe and effective.

Bioethical Principles

I will start by defining and explaining the four principles of bioethics according to the definitions from Tom Beauchamp and James Childress, who are often referred to as the fathers of modern American bioethics: autonomy, beneficence, justice, and nonmaleficence. Then I will apply their definitions of these four principles to the COVID-19 vaccine mandates.

The first bioethical principle we will discuss is autonomy. Autonomy is personal self-governance, which is the "personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice" (Beauchamp, 2003). In other words, autonomy means self-rule and refers to the individual making informed voluntary choices for themselves without the influence of bias (even if it is only a little), coercion, pressure, or duress (Ponesse, 2021). Autonomy is undermined by coercion, pressure, or manipulation. Autonomous individuals act freely following their self-chosen plan. This means freedom from external constraints and the presence of critical mental capacities like intending, understanding, and voluntary decision-making capacity (Beauchamp, 2003). You recognize their values and beliefs by respecting them and taking certain actions. Autonomy fails when others control someone or the person is incapable of acting based on their desired plan. Autonomy of action should not be subjected to control by other people; people should make their own decisions without the influence of others. Respecting the autonomy of a self-determining agent is to recognize them as entitled to determine their destiny concerning how they view the world (Beauchamp, 2003). In a medical context, patients must make choices based on the perceived intrinsic value of those choices and not for any other reason (Ponesse, 2021). For example, your decision to undergo surgery must be based on its benefits, as you understand them, and not pressure from doctors or the public. Autonomous actions should not be subjected to controlling constraints by others; autonomy requires both respectful disclosures of information and other actions that foster autonomous decision-making. Professionals in healthcare are obligated to disclose information, probe for and ensure understanding and voluntariness, and foster good decision-making (Varkey, 2021).

Informed consent is an individual's autonomous authorization of medical intervention or participation in research, and the individual must agree to something through an act of informed and voluntary consent. Informed consent requires that the person: must be competent to understand and decide; receives a full disclosure; comprehends the disclosure; acts voluntarily; and consents to the proposed action (Varkey, 2021).

Incompetence involves a person's inability to state a preference or choice, reason through a life decision, and understand one's situation and its consequences. Examples include infants and children and incompetence due to developmental, mental, or physical disorders. In a person who once was autonomous but has since become incompetent, their previously expressed preferences are to be respected (Varkey, 2021). For someone incompetent, they need a surrogate decision-maker. The surrogate can use either a substituted judgment standard (what the patient would want in the circumstance) or use the best interest standard (what would bring the highest net benefit to the patient by weighing risks and benefits) (Varkey, 2021).

Disclosure is very important when it comes to informed consent. Professionals must disclose information in a way that patients can understand, not use technical jargon. Physicians must disclose facts that patients consider material when deciding to refuse or consent to something (Beauchamp & Childress, 2019). Physicians need to disclose information that they think is material. Healthcare workers must also disclose their recommendations and why they want the patient to consent (purpose for consent) (Beauchamp & Childress, 2019). This has since expanded to include disclosure of the physicians' interests "unrelated to the patient's health, whether research or economic that may affect the physicians' moral judgments," as the California Supreme Court decided (Beauchamp & Childress, 2019). Physicians are obligated not to disclose confidential information given by a patient to anybody unless the patient authorizes such.

However, implied patient authorization shares necessary medical information among other medical and healthcare teams; a physician can disclose gunshot wounds, sexually transmitted diseases, and any exceptional situation that may cause major harm to another (Varkey, 2021).

Voluntariness is very important when it comes to autonomy and providing consent. According to Beauchamp and Childress, a person acts voluntarily when "he or she wills the action without being under the control of another person or the control of a personal physiological harm" (Beauchamp & Childress, 2019). There are three kinds of influences: coercion, persuasion, and manipulation. Coercion occurs if an intended and credible threat displaces a person's self-directed course of action, rendering even intentional and well-informed behavior nonautonomous (Beauchamp & Childress, 2019). For example, suppose a physician orders a reluctant patient to undergo cardiac catheterization and coerces the patient into compliance through a threat of abandonment. In that case, the physician's influence controls the patient (Beauchamp & Childress, 2019). In persuasion, a person comes to believe something through the merit of reasons another person advances. In contrast, manipulation is swaying people to do what the manipulator wants by means other than persuasion or coercion (Beauchamp & Childress, 2019). In healthcare, the most common form of manipulation is the deliberate act of managing information that alters a person's understanding of a situation and motivates them to do what the agent of influence wants them to do (Beauchamp & Childress, 2019).

As important as autonomy rights are, no autonomy right is strong enough to entail a right to unhindered autonomy or liberty. According to Beauchamp and Childress, "if an individual's choice endangers the public health, can potentially harm another party, or it involves scarce resources for which a patient cannot pay, it is morally acceptable to restrict their use of autonomy" (Beauchamp & Childress, 2019). There are four limiting liberty principles: the harm principle (a

person's liberty may be restricted justifiably to prevent harm to others caused by that person), the principle of paternalism (a person's liberty may be justifiably restricted to prevent harm to self, caused by that person), the principle of legal moralism (a person's liberty is justifiably restricted to prevent that person from behaving immorally), and the offense principle (a person's liberty is justifiably restricted to prevent offense to others by that person) (Beauchamp, 2003). These four principles represent an attempt to balance liberty. The harm principle is universally accepted as a valid liberty-limiting principle, unlike the other three.

The next two principles are nonmaleficence and beneficence. Nonmaleficence is very similar to beneficence, and they are often grouped together and used interchangeably. According to Beauchamp and Childress, nonmaleficence obligates us to abstain from causing harm to others; in simple terms, it can mean "above all do no harm" (Beauchamp & Childress, 2019). This principle entails do not kill, do not cause pain or suffering, do not offend, do not deprive people of the goods of life, and do not incapacitate (Beauchamp & Childress, 2019). Physicians should weigh the benefits against the burdens of all interventions and treatments to avoid those inappropriately burdensomely and choose the best course of action for the patient. Obligations of nonmaleficence also include not imposing risk of harm. A person can harm or place another person at risk without malicious or harmful intent, and the agent of harm may or may not be morally or legally responsible for the harm (Varkey, 2021). With nonmaleficence, there is also due care, which is taking appropriate care to avoid causing harm, as the circumstances demand of a reasonably prudent person. This means that the goals pursued justify the risks that must be imposed to achieve those goals. Grave risks require "commensurately momentous goals for their justification" (Beauchamp & Childress, 2019).

Beneficence is the obligation that healthcare providers have a duty to be of "benefit" to the patient and to take *positive* steps to prevent and remove harm from the patient (Beauchamp & Childress, 2019). The goal of providing benefits can be applied to individual patients and society as a whole. The principle calls for not just avoiding harm but also benefiting patients and promoting their welfare (Varkey, 2021). "We concur those obligations to confer benefits, to prevent and remove harms, and to weigh an action's possible goods against its costs and possible harms are central to moral life" (Beauchamp & Childress, 2019). Beneficence has two principles: positive beneficence and utility. Positive beneficence means agents must provide benefits to others, whereas utility means agents must balance benefits, risks, and costs to produce the best overall results (Beauchamp & Childress, 2019). The rules of beneficence include: protecting and defending the rights of others; preventing harm from occurring to others; removing conditions that will cause harm to others; and rescuing persons in danger (Beauchamp & Childress, 2019).

Paternalism is a part of beneficence, and it overrides people's autonomy for their benefit or the benefit of others. Paternalism is overriding someone's autonomy on the grounds of providing that person with a medical benefit; for example, this can take the form of involuntary committing to institutions for treatment, withholding medical information that patients asked for, denial of innovative therapy to patients who wish to try it, and government efforts to promote and protect public health (Beauchamp, 2003). Paternalism is justified if and only if the harms prevented from occurring to the person are greater than the harms or indignities (if any) caused by interference with their liberty and if it can be universally justified, under relevantly similar circumstances, always to treat persons in this way" (Beauchamp & Childress, 2019). Currently, the government, authorities, and medical professionals had taken a paternalistic approach when it came to the COVID-19 pandemic. Paternalistic acts can include forms of influence such as persuasion,

coercion, and manipulation. Paternalism involves intentional non-acquiescence or intervention in another person's preferences, desires, or actions to prevent or reduce harm to or benefit that person (Beauchamp, 2003). There are two types of paternalism, hard and soft. Hard paternalism requires that the benefactor's conception of best interests prevail. It may ban, prescribe, or regulate conduct in ways that manipulate individuals' actions to secure the benefactor's intended result (Beauchamp & Childress, 2019). Soft paternalism reflects the beneficiary's conception of their best interests, even if the beneficiary fails to adequately understand or recognize those interests or to fully pursue them because of inadequate voluntariness, commitment, or self-control (Beauchamp & Childress, 2019).

The last principle is justice. Simply put, it is interpreted as fair, equitable, and appropriate treatment of people. One justice category is distributive justice which refers to the fair, equitable, and appropriate distribution of healthcare resources (Beauchamp & Childress, 2019). This implies the fair distribution of goods in society and requires we look at entitlement. Distributive justice hinges on the fact that some goods and services are in short supply, and thus some fair means of allocating scarce resources must be determined (Varkey, 2021). There are a few valid principles of distributive justice: 1) an equal share, 2) according to need, 3) according to the effort, 4) according to the contribution, 5) according to merit, and 6) according to free-market exchanges (Varkey, 2021). Fairness to the patient undertakes a role of primary importance when there are conflicts of interest. An example of a violation of justice would be when a particular treatment option is chosen over others or an expensive drug is chosen over an equally effective but less expensive one because it benefits the physician financially or otherwise (Varkey, 2021).

Now let us apply these principles to the COVID-19 vaccine mandates. If these vaccines were like those for smallpox or measles, i.e., they are well understood, relatively safe, and

protected one against a pathogen and prevented the pathogen's spread, then under a pandemic, the ponderance of the above ethical considerations would seem to support vaccine mandates. According to Beauchamp and Childress, it is acceptable to violate someone's autonomy when their choices endanger the public or harm someone else. The choice might not be voluntary, but typically with vaccine mandates, you are given the information about the disease and the vaccine. By choosing not to get vaccinated, you are inevitably causing harm to the general public and others. But the argument is a little more nuanced than this. If the vaccine is equally effective in preventing one from catching the disease as it is in preventing its spread, then mandating that one person get the vaccine to protect another; or mandating that I get vaccinated to protect you does not follow any established ethical argument. In this case, one person's autonomy is completely trampled for very little utility since the other people are fully protected from catching COVID-19 based on their vaccination status. So, when this argument was used to justify the vaccine mandates early in the pandemic, a percentage of the population was pushed back. The correct argument based on utility is that healthcare resources are finite and that the unvaccinated would be more likely to catch COVID-19, which could lead to severe illness. This, in turn, would overwhelm hospitals and the healthcare system, taking away resources from those who need care for other purposes simply because one did not agree to get vaccinated.

Endangering the general public in this manner is a major issue for the government and healthcare workers. They need to do what is necessary to ensure the public's welfare is maximized, which means not needlessly overwhelming the healthcare system. This goes back to our principle of utility. Healthcare workers and the government take a paternalistic approach to ensure the public's welfare. Most of the time, this takes the form of hard paternalism. Their outcome is to

maximize the benefit for the greatest number of people and to do that, they might ban, prescribe, or regulate certain things to get you to take the vaccine.

Physicians and even the government also want to prevent harm to people. This follows the concept of beneficence, so they want to ensure everyone gets vaccinated. They have a duty to prevent and protect against harm, which in this case, is a disease. The government and healthcare workers must mandate the vaccine to protect one from the disease and prevent harm. Yes, a mandate is not a voluntary choice, but if it is for the common good of the public, it is ethical to limit someone's autonomy to prevent and protect against the harm that may come to them. But in applying the vaccine mandates, justice must be considered. The government and healthcare workers have to ensure the mandates are fairly applied to everyone. The government and healthcare workers must also ensure that vaccines are allocated effectively and efficiently. In applying a vaccine mandate, they want to benefit society as a whole. In this sense, the vaccines were made widely available and free to the public to serve the concept of justice and equity.

The above arguments for vaccine mandates boil down to two major issues: 1) beneficence (preventing harm to individuals) by having individuals get vaccinated, but which must be balanced against autonomy, and 2) utility. For most people, meaning those under 70 years old and without comorbidities, COVID-19 is no more deadly than a typical flu virus. Therefore, individuals were within their rights to "risk" not getting vaccinated (Huang, 2021). The flu vaccine is offered to those that want it but is not mandated for the general population. This would suggest that this argument alone cannot be used to justify vaccine mandates. However, there is no strong counterargument to utility. While for most of the population, the death rate for COVID-19 is no greater than for the flu, the morbidity or effects from COVID-19 are worse than the typical flu, and it can lead to serious conditions requiring significant treatment, including hospitalization,

unnecessarily tying up healthcare resources and potentially overwhelming the healthcare system. Thus, in total, the mandates applied at the beginning of the pandemic would seem to be ethically justified.

But are these mandates ethically justified today? We can apply these same principles to the COVID-19 vaccine mandates with what we know about the vaccines today. Much of the details related to the safety and efficacy of COVID-19 vaccines were previously discussed in the section on "Vaccine Safety and Efficacy." Without rehashing all the details, the vaccines do not prevent the spread of the virus (and were never even tested for such efficacy), and the protection against the virus wanes quickly, requiring constant boosters and is much less effective against newer variants. And finally, the vaccines have now been shown to suffer from multiple serious and debilitating side-effects related to the heart, immunosuppression, and many other factors, with excess deaths since the vaccines' introduction greater than from COVID-19.

From the beginning, it was clear that the autonomy of citizens was violated through the vaccine mandates. Certainly, all those people who had to take the vaccine or lose jobs were heavily coerced. But that was originally deemed acceptable for utilitarian purposes. This argument has remained the same, though it cast light on the ethics of those involved in controlling the flow of information at the beginning of the pandemic. People could not properly consent to these vaccines because all they were told was that they were “safe and effective.” Unfortunately, neither of these things was demonstrated or known at that time. It was by no means voluntary. The hard paternalistic approach meant withholding valuable information, misleading the public, coercing the public, and managing information about the vaccines in a manner that made any informed consent impossible. To consent properly, one must be informed of their consent. Not telling us the major side effects of the COVID-19 vaccines, misrepresenting data, and not answering any

concerns one had, are violating autonomy. Telling us we can work or we can lose our jobs is not a voluntary choice but one of coercion and manipulation.

Mandating a vaccine such as the COVID-19 vaccines also violated the concept of nonmaleficence do no harm, do not kill, and do not deprive people of a good life. Mandates have caused so many people harm and even caused death from coerced vaccination. Statistically, excess deaths have increased significantly since the vaccines were released, and it seems we all know someone that has either died or been seriously harmed because of the vaccines. By making us get an ineffective vaccine or preventing people from working and being able to make a living, or preventing someone from getting a necessary medical procedure, or just going to the store is depriving people of not having a good life but essentially the necessities of life. That is maleficence in the extreme, especially for a vaccine that can cause people to suffer serious adverse effects. In this case, mandating the COVID-19 vaccines violates the concept of nonmaleficence and beneficence.

The final matter has to do with utility. The vaccines do not prevent the transmission of COVID-19 nor protect one from getting COVID-19. The main benefit is the reduction in the severity of the disease for at least a limited period of time. In this sense, it may be useful in helping to relieve burdens on the healthcare system, but the effect is minimal and has to be weighed against the potential significant side effects. In addition, there are now reasonable and effective protocols for treating COVID-19 that, in many cases, can be performed by telemedicine without overwhelming the healthcare system. Because there is a limited benefit and significant downsides to the vaccines, the result is that general mandates today for the COVID-19 vaccines are not justified from the perspective of these bioethical principles.

Selective mandates are the better compromise, which may still apply even today. In this case, mandating vaccination for those at high risk of severe disease could be justified based on the harm principle (nonmaleficence/beneficence), as there is evidence that this would remove the grave public health threat of COVID-19 from those most susceptible, while not placing those with limited risk from COVID-19 in harm's way due to the possible risk of side-effects from the vaccine (Williams, 2021). In this case, vaccination's risk–benefit profile is also more clearly in the interests of those at the highest risk, so mandatory vaccination entails a less severe cost to them. Therefore, a selective mandate would create fairness in the distribution of risks and could be ethically justified even today.

Organ Transplant Case Study

This section focuses on ethical considerations for a particular subset of vaccine mandates: those for people requiring medical procedures. This will be handled as a case study focusing on an individual who could not receive a life-saving organ transplant because they did not receive the COVID-19 vaccine. I will break down the bioethical principles in this case for and against mandatory vaccination for organ transplant patients and determine if it was justified to withhold an organ because someone did not want to get the COVID-19 vaccine.

Brigham and Women’s Hospital in Boston, Massachusetts, dropped a 31-year-old father of two named D.J. Ferguson from its transplant waitlist because he was not vaccinated against COVID-19. He was due to receive a heart transplant. However, Mr. Ferguson was concerned about the side effects and the speed at which the vaccines were developed (Joseph, 2022). His mother, Tracy Ferguson, also a nurse, contends that her son was not against vaccines as he has had many.

Still, he was skeptical of the side effects of the COVID-19 vaccine because he has atrial fibrillation (an irregular and often rapid heart rhythm). D.J. Ferguson wanted to be assured by his doctors that his condition would not be worse or even fatal with the COVID-19 vaccine, but they never assured him (Press, 2022). He underwent emergency open-heart surgery to receive a mechanical heart pump. Still, due to this device, he will not be able to shower, swim, or live a normal life for the foreseeable future. The heart pump will likely keep him alive for five years, but Mr. Ferguson still requires a heart transplant due to his high-risk health condition (Roy, 2022). He is currently trying to get into another hospital that would allow him to receive a heart without the COVID-19 vaccine, but it is hard to transfer him due to his condition.

Human organs are extremely scarce resources. Not only is a donor heart a sacred gift that must be cared for well, but it is also in limited supply with thousands of people needing one, so the hospital's goal is to preserve patient survival and good outcomes post-transplant (Joseph, 2022). From an ethical framework, this would be a simple utilitarian argument. The principle of utility entails that "an action or practice [is] right if it promotes as much or more aggregate net good than any alternative action or practice" (U.S. Department of Health & Human Services, 2015). The hospital wants to make sure the person receiving the heart will survive and be able to use it because if not, they wasted a heart that could have gone to someone else in need. A COVID-19 mandate may also be useful in creating a selection bias. Those who agree to receive the vaccine may be more likely to comply with follow-up and immunosuppressive therapy post-transplant, increasing the odds of a better outcome (Hurst et al., 2022).

Consequently, the distribution of limited organs to unvaccinated patients would not maximize utility due to: (1) The increased risk of the patient potentially dying from COVID-19 infection (Hurst et al., 2022). As previously mentioned throughout this paper, age, and

comorbidities such as organ failure significantly increase a person's risk of dying from COVID-19. For example, the risk of death from COVID-19 infection in kidney transplant recipients is estimated at 25% in unvaccinated persons (Kricorian & Turner, 2021). (2) Transplant recipients must undergo immunosuppression to prevent transplant rejection, compromising the patient's ability to fight infections and putting them at a higher risk of severe COVID-19 disease and death. (3) Placing the organ in an individual with low levels of compliance (demonstrated by rejecting the COVID-19 vaccine) when success could be increased by giving the organ to someone more likely to be compliant to follow underlying follow-up care. Thus, to achieve higher net utility (a utilitarian perspective) across all candidates, it is ethically permissible for transplant hospitals to deny listing to a candidate expected to have a poor outcome (Kates et al., 2021).

The concept of "utility" is balanced by "justice." According to the Organ Procurement and Transplant Network:

> We are concerned not exclusively with the aggregate amount of medical good that is produced, but also with the way in which that good is distributed among potential beneficiaries. This does not mean treating all patients the same, but it does require giving equal respect and concern to each patient (U.S. Department of Health & Human Services, 2015).

This would preclude allocating organs based on race, socioeconomic status, gender, and other social characteristics. This is particularly relevant to mandating the COVID-19 vaccine, as minority populations, specifically, African Americans, are statistically less likely to obtain the COVID-19 vaccine, probably due to mistrust of the health care system (Hurst et al., 2022). Organs are scarce resources, and the principle of justice comes into play when allocating scarce resources.

As public health agents, transplant hospitals are ethically required to act as just, transparent, and prudent stewards of this scarce resource.

How net utility and justice might be balanced when considering the COVID-19 vaccine mandates varies by context. If transplant capacity or donor organs are extremely limited, stricter listing criteria may be acceptable to ensure that the greatest possible benefits for transplantation can be realized (Kates et al., 2021). Nevertheless, transplant hospitals are obligated to resist inequities affecting their patients. The strongest justification for strict vaccine mandates in transplant listing would be in societies where organs for transplant are very scarce, the vaccine is safe and effective, and vaccine refusal affects all groups equally. Transplant hospitals must ensure that their listing policies are clear and transparent to their candidates and that new policies are introduced to candidates proactively (Kates et al., 2021).

As we can see, this case is quite complicated. From a utilitarian argument, vaccine mandates are fully justified, but based on justice, the mandates would not seem ethical. Consequentially, let us look at the case more closely from the perspective of the COVID-19 vaccine being completely safe and effective, as was the assumption at the beginning of the pandemic. Regarding scarce resources such as a heart, the likelihood of success in treating the patient is a relevant criterion because "scarce medical resources should be distributed only to patients who have a reasonable chance of benefit" (Beauchamp & Childress, 2019). A heart can only be donated by the deceased, making it a very scarce resource, unlike a kidney or liver transplant, which are still a relatively scarce item. A physician needs to ensure that the person receiving the heart will survive because if the patient who received the heart dies, the heart has been wasted, resources in transplanting the heart were wasted, and someone else who needed a heart will not be able to get one. After receiving a transplant, one is immunocompromised and

extremely susceptible to infections. By not getting the vaccine, Mr. Ferguson is putting the new heart in harm's way. If Mr. Ferguson does not receive the COVID-19 vaccine and gets COVID-19, he will have a high probability of dying. COVID-19 is far worse and more deadly for people who are immunocompromised. By giving him the heart when there is a likely chance, he could get sick and die because he refused a simple, safe, effective vaccine that could improve his chances; the doctors are harming another patient who could use the heart. Once the doctors give someone a heart and they get sick and die, they cannot use that heart for another transplant. At that point, the doctors would not be able to care for another patient who needs a heart, causing them unintentional harm by not giving the heart to a person willing to do anything necessary to ensure a successful outcome, including accepting the COVID-19 vaccine.

According to Beauchamp, the doctors, in this case, “are not morally required to benefit persons on all occasions, even if we are in a position to do so” (Beauchamp & Childress, 2019). The doctors are not morally required to help Mr. Ferguson, especially because he is not vaccinated; they have duties to other patients that have a greater success for the outcome. The doctors have to weigh the benefits and risks of the surgery for the unvaccinated Mr. Ferguson and the benefits and risks of doing the surgery. One risk is that heart transplant surgeries are very expensive. If they waste the heart on someone who is going to die regardless of getting the transplant, they not only waste the heart but the time of a highly trained surgical team, money, and other resources. Giving Mr. Ferguson a heart when he is not vaccinated will be of greater harm to the hospital and its other patients. When it comes to any organ transplant, the doctors not only have a duty to the candidates/recipients, but they also have a duty to the families and the person they got the organ from. They must keep them in mind and do what is best for them and their organs. Would you want your liver going to an acholic? Do you want your heart to go to someone who will die

anyway? Doctors weigh the costs and benefits by deciding who gets the organs. If you are the sickest patient in the hospital, you won't get the organ as you are past saving. Suppose you are "first on the list," as claimed by David Ferguson. In that case, you probably are really sick, and the health care professionals involved in his care would want to reduce the risk of infection and other complications as much as practical, involving COVID-19 vaccination.

The counterarguments in this case primarily fall under the auspices of autonomy, justice, and nonmaleficence. The doctors violated Mr. Ferguson's bodily autonomy and harmed him by not giving him a heart transplant. To properly consent to something, it has to be voluntary, and the person has to be informed to understand what they are consenting to. The Brigham and Women's Hospital doctors did not answer his concerns regarding the vaccines' efficacy and safety. He was concerned about the side effects and what it would do to his heart condition. Mr. Ferguson was doing his duty as a patient to be informed, but the physicians did not help with his concerns. Imposing the vaccine mandate constrained autonomy by imposing a grave consequence for not getting vaccinated. They gave him a choice: get vaccinated and get a heart or do not get vaccinated or get a heart resulting in a shortened life. That is not a voluntary choice and a cruel game to play when someone suffers greatly.

Nonmaleficence means, above all, do no harm. The doctors not giving him a heart because he is not vaccinated against COVID-19 is causing him harm. They also have a duty to care for their patients and prevent and remove harm. He needs the heart to live, and denying him a heart for not being vaccinated is harmful and unjust to Mr. Ferguson and his family. His heart is bad and causing him harm, and part of a doctor's duty under beneficence is to prevent and remove harm. Therefore, they have a duty to replace what is causing him harm, whether vaccinated or not. Part of the rules for nonmaleficence (as stated earlier) is not to cause pain or suffering and not deprive

others of the good life. He should not be denied a heart just because he is not vaccinated due to concerns about it causing later health complications. The doctors are causing him pain and suffering by denying him a heart.

Because organs are such a scarce commodity, the stronger case is probably based on utility, but if the mandate is implemented properly, it should also address most concerns with justice. COVID-19 vaccine mandates could enhance the net utility from transplantation across all candidates, benefit the overall public, and protect vulnerable recipients/candidates; for these reasons, requiring COVID-19 vaccine mandates for transplant listing may be ethically justifiable as long as implementation addresses other ethical concerns (Kates et al., 2021). Some of these ethical concerns include empowering candidates to make informed autonomous decisions about vaccination by providing them with culturally appropriate and understandable information about the vaccines while allowing for sufficient time to consider that information (Kates et al., 2021). And for that reason, COVID-19 mandates should not be immediately imposed upon candidates already listed for a transplant. Instead, transplant hospitals should establish a timeline to reach out to candidates that are not vaccinated, inform them of the policy change, provide them with information on the vaccines so that they can make an informed decision, and allow them time to consider. After a reasonable consideration interval has been met, candidates who have not been vaccinated and have not already transplanted could possibly face removal from the waiting list (Kates et al., 2021). Transplant hospitals should also anticipate and seek to mitigate the impact of vaccine mandates on transplant equity. They should do this by familiarizing themselves with patterns of vaccine acceptance in their populations and be prepared to address vaccination concerns specific to disadvantaged groups (Kates et al., 2021). COVID-19 vaccine mandates should be implemented in a way that is transparent to the candidates and the public.

Now let's look at this case with our current knowledge of vaccines. Mr. Ferguson has a heart condition, atrial fibrillation, that may be made worse by now-known side effects of the vaccines, including coagulation disorders, myocarditis (inflammation of the heart muscle), and other forms of acute cardiac injury that occur at nearly twice the rate in vaccinated individuals compared to the unvaccinated (Fraiman et al., 2022). Such effects would likely be deadly for Mr. Ferguson, so he was fully within his right to be cautious. The COVID-19 vaccines do not prevent one from getting COVID-19 nor stop transmission, and the COVID-19 vaccines are also immunocompromising, which would enhance issues associated with post-transplant care. Yet, for him to get a heart transplant, the doctors want Mr. Ferguson to get vaccinated against COVID-19 so that he does not get COVID-19 since he will be immunocompromised after the surgery. But the vaccines will also cause him to be further immunocompromised and will not necessarily prevent him from catching COVID-19. In this case, are there any benefits to being vaccinated? Probably not. Data suggests that a substantial proportion of transplant recipients likely remain at risk for COVID-19 even after two doses of the mRNA vaccine because their bodies are generally incapable of creating a significant antibody response to the vaccine (Boyarsky et al., 2021). This is a no-win scenario. To get a transplant, Mr. Ferguson needs to live a prolonged life; he is being forced to accept a vaccine that has only downsides and could even cost him his life. Therefore, given this information, even the utility argument can now be questioned, as Mr. Ferguson may have a better chance of surviving the heart transplant if he were not vaccinated.

Of course, all the other ethical arguments against a mandatory vaccine in this case still hold but are even stronger. The doctors violated his bodily autonomy by mandating the vaccine. As stated earlier, he cannot properly consent to the mandate when he is not making a voluntary choice, nor did they answer his concerns about the side effects of vaccines, which are significant and

legitimate concerns. And refusing to do a transplant because he is not vaccinated is not only causing him harm, but the doctors are not preventing and removing the harm; they are imposing a death sentence. The doctors giving an already sick person a vaccine that will make them sicker and cause more issues than they prevent is causing harm, pain, and suffering. Not only is the harm physical but mental. A major French study on the effect of vaccine mandates for cancer patients concluded that while the vaccine might not necessarily improve the survival of cancer patients, "the anxiety generated by this vaccine may have had a non-negligible effect on their quality of life (i.e., happiness)" (Stoeklé et al., 2022). That goes against the principle of nonmaleficence. Not doing the transplant because he does not want to get an unsafe and ineffective vaccine seems counterintuitive and completely unjust. In this case, it represents discrimination that, unfortunately, leads to a death sentence. Having an underlying heart issue and getting a shot that causes heart damage, causes immunosuppression, and in the end, does not even prevent someone from coming down with COVID-19 is a recipe for disaster. The benefits of the vaccine do not outweigh the harm. So, in this case, by all ethical arguments, it would be completely unethical to force a vaccine mandate on Mr. Ferguson under the threat of withholding a life-preserving treatment.

Ethical Considerations for Vaccine Mandates for Healthcare Workers

Not only did private businesses, schools, and governments mandate COVID vaccines, but healthcare facilities also mandated the COVID-19 vaccine for their workers. It is not unusual for healthcare facilities to mandate vaccines for Hepatitis B, tuberculosis, flu, and other serious infectious diseases for their healthcare workers. And like many Americans, healthcare personnel, even those fighting on the frontline of the pandemic and already recovered from COVID-19 with

natural immunity, were given a choice to get vaccinated or lose their job. Many nurses and doctors during the pandemic's beginning were hesitant and skeptical about getting the COVID-19 vaccine. Still, they got it anyway because they wanted to ensure the safety of their patients (Mayberry, 2022). Other healthcare personnel were hesitant about getting the COVID-19 vaccines because they were concerned about safety, doubted the effectiveness, felt they had natural immunity or did not deal directly with patients. Thus, they felt they did not need to get the shot (Gur-Arie et al., 2021). But mandates changed the landscape, and as discussed earlier, the COVID-19 vaccines are vastly different from other vaccines. Consequently, this section focuses on the arguments for and against mandatory vaccination of healthcare workers.

Mandating the COVID-19 vaccine for healthcare workers, on top of the other required vaccinations usually needed to hold such jobs, would not seem to be such a stretch. And because of the type of job they perform, mandatory vaccines for healthcare employees involve justifiable limitations on personnel autonomy to ensure fulfillment of their professional duties. As such, there are two main arguments supporting such mandates. The first falls under the “do no harm” category or the principle of beneficence and non-maleficence, already heavily covered in this paper (Olick et al., 2021). Protecting patients is one of the key justifications for requiring healthcare personnel to be vaccinated or show immunity against other occupational threats such as hepatitis B, measles, mumps, rubella, diphtheria, and pertussis (Bowen, 2020). Healthcare employees work with vulnerable populations like immunocompromised and older people and must protect all the people they serve (Gur-Arie et al., 2021). In addition, even early during the pandemic, there was growing evidence that super-spreading events were a typical feature of COVID-19 transmission and that healthcare personnel could be involved in such events (Adam et al., 2020). Thus, nurses and doctors are expected to get vaccinated to ensure the safety of those patients and, ultimately, their

families. They have a duty to promote the patient's welfare, to prevent harm, and to be of benefit to the patient, which includes not passing on COVID-19.

There have also been calls for healthcare personnel to be vaccinated against COVID-19 based on a utilitarian view and because healthcare personnel have a "duty to care" (Gur-Arie et al., 2021). Requiring vaccination allows maxim benefit to the public because healthcare personnel would be healthy and able to work (care for their patients) since they would not be out of work or sick from COVID-19.

There are also several ethical and practical reasons for not mandating the COVID-19 vaccines in the healthcare industry. From an ethical standpoint, not only does mandating the COVID-19 vaccines call into question the moral integrity of healthcare workers, but it also violates their autonomy. Many healthcare workers have reasons for vaccine hesitancy and refusal. After all, these are usually a well-informed part of the population regarding health issues, and possibly even from firsthand experience, they have developed concerns about the vaccine's effectiveness, efficacy, and side effects. A major aspect of autonomy is being able to consent properly to something. Mandates do not allow a person to make voluntary consent. Once the COVID-19 vaccines were rolled out, healthcare workers questioned the efficacy and safety and how the vaccine would affect them, but in general, they were ignored (Mayberry, 2022). When something is mandatory, no explanation is necessary (Pruski, 2021). Contrast this with a patient, who ultimately has the right to know what they are consenting to, and the healthcare worker has to provide them with such information in a way that they will understand, even if that means the patient ends up changing their mind. But the same opportunity was not offered to healthcare workers. To consent properly, one has to be informed of what they are consenting to. Healthcare

workers were not informed about the risks and efficacy of the vaccines even when they asked. They were instead met with, “take the vaccine or lose your job” (Mayberry, 2022).

Here is just one example of the COVID-19 vaccine mandates in action for healthcare personnel. Angela Loerzel was a licensed clinical social worker in Oregon and Washington who asked questions about the COVID-19 vaccines to determine whether it was safe. Still, her questions and concerns were ignored (Mayberry, 2022). Angela Loerzel Swafford suffers from venous malformation, which is when the veins in the body develop in unusual ways. This is one of the reasons she tried to question the vaccines before getting it. Angela Loerzel Swafford loved her job and wanted to keep it, so she had no choice other than to take the vaccine. But she ended up suffering severe adverse reactions to the vaccine. Ms. Swafford is now suffering from neurological side effects that have affected her life, so she can no longer drive or work (Mayberry, 2022). She said, “I did the shot to keep everything and more so to protect the community I work in because that’s what they were telling me, but in the end, I lost everything. I am not the same” (Mayberry, 2022). Not only was her autonomy violated, but also her duty as a healthcare worker. In this one example alone, one can make a case that the physicians who did not answer her questions and concerns violated their duty of nonmaleficence and beneficence. The physicians knew about her underlying health condition and how that was a concern, but instead of informing her as they should have, they ignored her because it was easier to push the mandate. The vaccine caused Angela serious harm, and the physicians did not uphold their duty to prevent harm, care for her, and inform her. They only cared about getting everyone vaccinated, leading Angela to suffer serious harm.

Then there are the unintended consequences of mandates. For one, mandates risk eliciting psychological reactance, meaning it is natural to feel or exhibit anger and negative perceptions in

response to a loss of freedom or limited alternatives. Among frontline healthcare workers, this could reinforce and even increase vaccine hesitancy towards COVID-19 vaccination as well as other unrelated vaccines and add to the growing mistrust of government and pharmaceutical companies (Sprengholz et al., 2021). Trust issues also disproportionately impact minorities. Perhaps because of past unethical practices that have damaged trust, such as the infamous Tuskegee syphilis trials, Black and minority ethnic staff are less likely than other healthcare workers to have been vaccinated against COVID-19 (Kadambari & Vanderslott, 2021). If they are similarly less likely to comply even with a mandate, they will be disproportionately impacted by this policy, which would fit the current definition of discrimination (disparate impact).

Even if only a small percentage of healthcare workers quit because of the mandates, this will sharply impact hospitals, most of which already suffer from a shortage of nurses. Because resources are already stretched, it will only take a small percentage of healthcare workers to quit rather than get vaccinated to have a significant impact on healthcare delivery. Common sense and strong evidence show that lower staffing levels are associated with increased inpatient mortality (Rodger & Blackshaw, 2022). Finally, given that the rates of vaccine hesitancy are very high among young people, the impact of the vaccine mandate on recruitment to the healthcare profession should also be considered (Fazel et al., 2021). Mandates may discourage some individuals from pursuing a healthcare career, particularly if mandates will be in place for the long term and remain a condition for employment. Or even worse, the lesson learned is that the healthcare profession is prone to ill-considered mandates for experimental drugs with unproven efficacy and unknown long-term safety. Any reduction in future enrollment in nursing schools spells a disaster for healthcare in this country. The consulting firm McKinsey & Company predicts

a shortage of 200,000 to 450,000 nurses by 2025, significantly attributed to the COVID-19 pandemic (Berlin et al., 2022).

It is clear from these unintended consequences that the ethical argument for utility begins to evaporate and even swings to the side that COVID-19 mandates should not be put in place for healthcare workers. Because, in the end, the mandates will do more to reduce the overall healthcare workforce today and in the future. The other pro-mandate argument was beneficence (do no harm). But this argument also loses its credence as even early in the pandemic; it was realized that immunity conferred by current vaccines waned rapidly; six-months after vaccination, healthcare workers without boosters have similar immunity to the unvaccinated who have previously been infected (as most healthcare workers were during the pandemic), and therefore pose a similar risk (Rodger & Blackshaw, 2022).

Therefore, while it is possible to justify some vaccinations in the healthcare profession, such as hepatitis B, measles, mumps, rubella, and diphtheria, which are well-established and fully understood vaccines that are very effective and safe, experimental COVID-19 vaccines do not fall into this category. In addition, there is no firm argument for the utility or beneficence of using the vaccine mandates for healthcare professionals. These COVID-19 mandates are even less ethical when one considers that there are safe and effective alternatives to being vaccinated. For one, personal protective equipment (PPE) is effective against the spread of COVID-19 (Gur-Arie et al., 2021). The other solution is for unvaccinated workers to undergo a daily rapid antigen testing regime (Rodger & Blackshaw, 2022). Under these conditions, most infections would be quickly detected. Even though these tests are considerably less accurate than PCR test, their higher false positive rate is not a major issue compared to the alternative, which is to terminate the employment of the unvaccinated (Allan-Blitz & Klausner, 2021). In addition, this approach has major safety

advantages compared to vaccine mandates. If they contract COVID-19, vaccinated workers could potentially be infectious in the workplace for a few days and possibly longer if they are asymptomatic. Therefore, unvaccinated workers, who are tested daily, will likely pose a lesser risk than vaccinated workers, particularly as the latter group's immunity wanes.

Conclusion

This paper is not "anti-vax" and does not claim that all vaccine mandates are unethical; most vaccine mandates are ethically justified. This paper's point was to examine the COVID-19 vaccine mandates and decide if they were ethically justifiable. Not only do healthcare workers have a duty to protect us, but so does the government. The government acted in what we were led to believe was in the best overall interests of the country and the greatest good for the public. Decisions were made based on experience with past pandemics and conventional vaccines to push the COVID-19 vaccines based on a new technology, mRNA, for which no experience or precedent existed. The COVID-19 vaccines and even COVID-19 are not like other diseases and vaccines. Our autonomy was stripped away, and many people got harmed and even died from the vaccines. Estimates in the U.S. are that at least 150,000 to 388,000 people have died from the vaccines, and many have been negatively impacted, but we may not know the total damage done by the vaccines for years (Huber, 2022).

Early intervention during the pandemic seemed justified based on utility, doing what was best for the public and the overall healthcare system. The decisions were made during a panic, and the government acted without full knowledge of the consequences of the vaccine or ignored early signs that the vaccine may be problematic and that the disease itself was not any more serious for

the general population than the flu. Today it is clear that the COVID-19 vaccine mandates are unethical, autonomy was breached without the full informed consent of the population, damage due to the vaccine represents maleficence, and utility was never demonstrated as the vaccines neither prevent the spread of the disease nor prevent someone from catching the disease.

With this slow realization, most of the COVID-19 vaccine mandates have faded from the site. Many are currently tied up in the courts, but while being heard, court injunctions prevent the use of mandates in nearly all instances (Staff, 2022). On November 12, 2022, the U.S. Court of Appeals for the Fifth Circuit temporarily halted OSHA's rule, requiring workers at large companies to get vaccinated or undergo weekly testing. On December 7, the U.S. District Court Judge for the Southern District of Georgia issued a preliminary nationwide injunction that halts national enforcement of the Biden administration's vaccine mandate for federal contractors and federal employees. On November 30, 2022, following a lawsuit brought by 14 states, the U.S. District Court for the Western District of Louisiana granted a nationwide preliminary injunction, halting enforcement of the federal vaccination mandate for healthcare workers. And finally, in January 2023, the DOD rescinded COVID-19 vaccine mandates for the military, including all active duty, national guard, and reserve personnel. In addition, many states have passed legislation blocking vaccine mandates of various types (Staff, 2022).

The mistake in mandating the COVID-19 vaccines seems to be slowly realized and self-correcting. But the problems induced by the early mandates will linger a lot longer. Even before the pandemic, vaccine hesitancy was recognized, with the WHO identifying it as one of the top ten global health threats in 2019 (World Health Organization, 2019). The most prevalent reasons for refusing vaccinations relate to concerns regarding vaccine safety, distrust of the pharmaceutical sector, and a growing distrust in government (Larson et al., 2018). The current handling of

COVID-19 in the US and throughout many parts of the world, including the myriad of vaccine mandates imposed by the Executive Branch of the Federal Government, private companies, universities, health facilities, and other entities, did very little to build public faith and trust in the pharmaceutical industry and the government at large. The now constant drip of negative news on the efficacy of the vaccines and the numerous and growing list of serious side effects caused by the vaccines will only increase the amount of vaccine hesitancy against even current safe and effective vaccines and, equally problematic, will slow the voluntary take-up of vaccines and make it more difficult to impose mandatory vaccine mandates when the next epidemic is realized.

That is why it is important to begin a discussion in this country about what was done right and incorrectly during the recent pandemic and come up with a well-thought-out response before the next pandemic strikes. A national debate between bodily autonomy and the general good of society concerning vaccine mandates needs to occur now. At the same time, the situation is fresh in my mind but no longer an emergency. In contrast, a reasonable debate cannot be had during the next pandemic, when emergency measures will force the governments' hand to act without the chance for an enlightened conversation. In that regard, this paper is a first step in preparing for these future discussions.

Finally, as the reader of this paper, ask yourself: What world would you rather live in, one where your happiness or life can be taken away from you for the sake of others or where you're acknowledged as a rational being? A world based on trust or a world full of mistrust and deception. A world full of careful calculations or a world with quick decision-making? The decision is yours. If we could hit a redo button, would things be different knowing what we know today? And can we be prepared to do the right thing in the future?

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