

Not Being Vaccinated Is Not Acceptable By David Ropeik Critical Review

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David Ropeik's 2011 opinion article "Not Being Vaccinated Is Not Acceptable" argues that refusal of recommended vaccination can impose health and financial risks on other people and that society sometimes restricts individual behavior to prevent harm. The original review agrees that vaccination is less costly than responding to outbreaks but objects to requiring infected people to remain at home. A careful evaluation should separate several questions that the original response blends together: whether vaccines are safe and effective, whether vaccination should be required in particular settings, how medical and nonmedical exemptions should operate, and when isolation or quarantine is justified during an infectious period. Vaccination prevents disease before exposure, while isolation limits contact by a person who is ill or infectious. Both policies can protect communities, but each needs evidence, proportionality, access, due process, and clear communication. (Ropeik, 2011)

Summary of Ropeik's Argument

Ropeik compares vaccine refusal with other regulated risks such as drunk driving and smoking in shared spaces. His central claim is that personal freedom has limits when one person's decision raises the probability of harm to others. He points to measles outbreaks and the public resources required for contact tracing, post-exposure prophylaxis, quarantine, testing, and treatment. The article emphasizes that vaccine-preventable disease is not merely an individual matter because people who cannot be vaccinated or who respond poorly to vaccines depend partly on high community coverage.

The Harm Principle

The strongest ethical basis for vaccine requirements is the harm principle: government may restrict liberty to prevent significant harm to others. The principle does not justify every mandate. Authorities must show that the disease is serious, the intervention is effective, the burden is proportionate, and less restrictive alternatives are insufficient. Requirements can be more defensible in healthcare, schools, outbreak settings, or occupations involving vulnerable people than as one universal rule for every vaccine and adult. Ethical policy distinguishes contexts rather than treating all refusal identically.

Measles as a Public-Health Example

Measles is one of the most contagious human infections. It spreads through the air and can remain infectious in a room after an ill person leaves. Complications include pneumonia, encephalitis, hospitalization, long-term neurological injury, and death. The World Health Organization reported in July 2026 that vaccination prevented nearly 59 million deaths between 2000 and 2024, yet global coverage remained below the level needed to prevent outbreaks in many places. Measles therefore remains an appropriate example of how local gaps in vaccination can produce wider risk. (World Health Organization, 2026)

MMR Vaccine Effectiveness

Two recommended doses of measles-containing vaccine provide strong protection for most people. No vaccine is perfectly effective, which is why high coverage matters. An unvaccinated infected person can expose infants too young for routine vaccination, pregnant people without immunity, immunocompromised patients, and vaccinated people whose immune response is incomplete. Community protection is not an invisible wall that makes exposure impossible, but it lowers the chance that the virus reaches a vulnerable person.

Vaccine Safety

Vaccines can cause side effects, usually temporary effects such as soreness or fever. Rare serious reactions can occur and are monitored through safety systems. Ethical communication should neither claim zero risk nor present anecdotes as equal to controlled evidence. Recommendations compare the known risks of vaccination with the risks of infection and transmission. Safety findings are updated when evidence changes. Trust is strengthened when public-health agencies acknowledge uncertainty, investigate signals, and explain how recommendations are made.

Vaccines and Autism

The original review refers to claims that vaccination causes autism. The claim became prominent after a 1998 paper about MMR that was later retracted and found to involve serious misconduct. Extensive research across countries has not found a causal link between vaccines and autism. In December 2025, the World Health Organization's Global Advisory Committee on Vaccine Safety reviewed evidence published through August 2025 and reaffirmed that available evidence does not support a causal relationship. Autism is a neurodevelopmental condition, and families deserve reliable support rather than blame directed at vaccination. (World Health Organization, 2025)

Why the Myth Persists

Autism traits often become noticeable during the same period when children receive several routine vaccines, creating a temporal association that can feel causal. Personal stories are emotionally powerful, while large epidemiological studies are less vivid. Distrust of institutions and exposure to repeated misinformation can reinforce concern. Dismissing parents as ignorant is ineffective. Clinicians should listen, explain what evidence can and cannot show, and discuss the disease risks prevented by vaccination.

Medical Exemptions

Some people should not receive a particular vaccine or should delay it because of a documented medical condition, prior severe reaction, immune status, or other clinical reason. Medical exemptions should be based on recognized guidance and individualized assessment. These individuals are one reason community vaccination is ethically important. A mandate without appropriate medical exemptions would be unsafe and unjust.

Religious and Personal-Belief Exemptions

Jurisdictions differ in whether they allow religious or personal-belief exemptions for school requirements. Broad exemptions can cluster geographically and reduce community protection. At the same time, limiting them affects conscience and parental authority. Policymakers should evaluate local disease risk, exemption misuse, and whether alternatives such as education or exclusion during outbreaks are sufficient. Rules should be clear, applied consistently, and accompanied by convenient access to vaccination.

School Requirements

School vaccination requirements protect a setting in which children spend long periods in close contact. They also ensure that protection is not determined only by parental knowledge or ability to navigate healthcare. Requirements should include free or affordable access, record assistance, medical exemptions, and procedures for students lacking documentation. Punishing a child for administrative barriers or poverty does not advance public health. Outreach should precede exclusion wherever immediate outbreak risk permits.

Healthcare Workers

Healthcare workers interact with patients at elevated risk. Vaccination policies may be justified for diseases that can be transmitted in care settings, particularly when the vaccine reduces infection or severe disease and when alternative controls are weaker. Employers should consider medical accommodation, disability and religious law, protective equipment, testing, reassignment, and current evidence. A policy should not use the label “healthcare worker” without evaluating actual exposure and role.

Isolation

Isolation separates a person who is infected and contagious from others. The original reviewer rejects asking infected people to remain home because it might discourage treatment. This concern about stigma and concealment is valid, but the conclusion is too broad. Advising or requiring a contagious person to avoid close contact can be one of the most direct ways to protect others. The policy should provide medical access, paid leave, food, housing support, and clear criteria so that isolation is feasible and not punitive.

Quarantine

Quarantine concerns people who may have been exposed but are not yet known to be ill. It is more restrictive when applied broadly and requires strong justification. Vaccination status, testing, incubation period, exposure intensity, and the availability of symptom monitoring may affect recommendations. Authorities should use the least restrictive measure likely to work and provide a way to review orders. Isolation and quarantine are not substitutes for vaccination, but they can limit an outbreak after exposure occurs.

Contact Tracing

Contact tracing identifies people exposed during the infectious period and connects them with testing, vaccination, immune globulin where indicated, monitoring, or temporary precautions. Smaller events and accurate attendance records may simplify tracing, but the main goal is timely identification, not surveillance for its own sake. Privacy should be protected, and only necessary information should be shared. Cooperation increases when people trust that disclosure will not lead to punishment unrelated to health.

Outbreak Costs

Even a small outbreak can require substantial public expenditure because health departments must investigate cases, contact many people, arrange laboratory testing, provide prophylaxis, and manage exposure in schools, hospitals, or transportation. Families also lose wages and incur travel or medical costs. Economic analysis supports prevention, but money should not become the sole argument. Avoiding illness, disability, fear, and preventable death is the primary public benefit.

Access Before Coercion

A society cannot fairly penalize undervaccination while clinics are distant, appointments unavailable, records confusing, or vaccines unaffordable. Mobile clinics, school programs, reminders, paid time, language access, and reliable supply should come first. Some communities have lower coverage because of access barriers rather than ideological refusal. Treating every missed dose as deliberate opposition misdiagnoses the problem.

Trust and Historical Harm

Medical distrust can be rooted in discrimination, experimentation without consent, forced sterilization, poor treatment, or exclusion from healthcare. Public officials should not use education as a substitute for institutional accountability. Trusted local clinicians and community organizations can help, but they should not be used merely to deliver a predetermined message. Transparency about benefits, risks, uncertainty, funding, and error correction is necessary.

Risk Communication

Communication should use absolute as well as relative risk where possible, explain expected side effects, and state what symptoms require medical care. Messages based only on fear can backfire. Correcting misinformation works better when the explanation is clear and respectful and when the recommended action is convenient. People should understand that scientific confidence does not require claiming that evidence is infallible; it means conclusions are supported by converging methods and remain open to monitoring.

Individual Choice and Community Responsibility

Medical consent is a central ethical principle. Yet infectious disease differs from treatment affecting only the patient because transmission creates external risk. A parent's decision can expose other children and adults. Community responsibility does not erase bodily autonomy; it increases the

burden on policymakers to show why a requirement is necessary and designed fairly. Different diseases and vaccines may justify different balances.

Polio

The original essay describes polio as nearly ended worldwide. Vaccination has eliminated wild poliovirus from most countries and reduced disease dramatically, but eradication has not been completed. Wild poliovirus transmission has remained concentrated in a small number of places, while vaccine-derived outbreaks can occur where coverage is low. Polio demonstrates both the power of vaccination and the difficulty of finishing eradication amid conflict, distrust, mobility, and unequal health infrastructure.

Mandates and Penalties

Penalties should be proportionate to the setting and goal. School exclusion during an outbreak may directly reduce transmission, while criminal punishment for ordinary hesitancy would likely be excessive and counterproductive. Civil requirements, counseling, documentation, and temporary restrictions can protect health with less coercion. Policymakers should measure whether a rule improves coverage and whether it creates unequal burdens.

Compensation and Reciprocity

When society asks people to accept a small risk for communal benefit, fairness supports systems that treat and compensate rare serious vaccine injuries without requiring impossible proof or lengthy litigation. Reciprocity also means protecting workers who need time for vaccination or side effects. Public responsibility should accompany public expectations.

The Role of Clinicians

Doctors, nurses, and pharmacists should recommend vaccination based on current guidance, review contraindications, and respond to questions. They should avoid humiliating patients or overstating certainty. A strong recommendation from a trusted clinician is often influential. Repeated conversation may be more effective than one confrontation. Clinicians also need systems that prevent missed opportunities and document doses accurately.

Critical Evaluation of Ropeik's Tone

Ropeik is persuasive when he emphasizes external harm and outbreak cost. His framing can become counterproductive when refusal is treated mainly as unacceptable behavior requiring social condemnation. Hesitancy includes several groups: people facing access barriers, people with specific safety questions, people influenced by misinformation, and committed ideological opponents. The intervention should match the reason. Moral blame may harden identity, whereas clear requirements combined with respectful communication can protect health without unnecessary hostility.

My Position

I agree that recommended vaccination is a responsibility when refusal creates a substantial risk to others and safe, effective vaccination is accessible. I also believe that requirements need medical exemptions, evidence, and fair procedures. I disagree with a blanket rejection of home isolation for infectious people. Staying away from others during a contagious period can be essential, but support and confidentiality should prevent the measure from becoming punishment. Awareness programs are important, yet education alone may not control a highly contagious outbreak when coverage falls below protective levels.

Conclusion

Ropeik's article correctly argues that vaccine refusal can impose costs and health risks beyond the individual. Measles remains a serious airborne disease, and vaccination has prevented tens of millions of deaths. Evidence does not support a causal link between vaccines and autism. Public policy should nevertheless distinguish vaccination requirements, medical exemptions, isolation, quarantine, and communication. Effective programs provide convenient access, monitor safety, protect privacy, compensate rare injury, and use the least restrictive measure capable of preventing harm. Vaccination is both a personal medical decision and a community-health action. The strongest policy combines responsibility with trust, evidence, and fairness rather than relying only on condemnation.

Works Cited

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