

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-I-10

Subject: Routine Universal Immunization of Physicians for Vaccine-Preventable Disease
(Resolution 922-I-09, Resolution 928-I-09)

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Daniel B. Kimball, Jr., MD, Chair)

1 This report by the Council on Ethical and Judicial Affairs (CEJA) was developed in response to
2 Resolutions 922-I-09 and 928-I-09, which were both referred. Resolution 922-I-09, "Mandatory
3 H1N1 Vaccine for Health Care Workers," which was presented by the American Association of
4 Public Health Physicians, asks our CEJA and the Council on Science and Public Health jointly
5 study and issue guidance on mandatory H1N1 vaccination for health care workers. Resolution
6 928-I-09, "Mandatory Immunization of Health Care Workers Against Seasonal and 2009
7 H1N1 Influenza," which was presented by the Infectious Diseases Society of America, asks our
8 American Medical Association (AMA) to reaffirm its support for universal influenza vaccination
9 of health care workers and support universal immunization of health care workers against seasonal
10 and 2009 H1N1 influenza through mandatory vaccination programs except under certain defined
11 circumstances. The resolution further asked the AMA to support policies that require health care
12 workers who are not vaccinated to wear masks or be reassigned from direct patient care.

13

14 INFECTIOUS DISEASE & PATIENT WELFARE

15

16 Nosocomial infection is a major problem for patient safety.¹ Such infections result in prolonged
17 hospital stay, long-term disability, antimicrobial resistance, additional financial burden, high costs
18 for patients and their families, and excess deaths.¹ Influenza outbreaks in particular can have
19 serious implications on patient morbidity and mortality. In the United States, an average season of
20 influenza results in tens of thousands of deaths and as many as 200,000 hospitalizations due to
21 influenza-related causes.² The burden of nosocomial infection is increased in high-risk patients
22 such as the elderly, infants and children, pregnant women, those admitted to ICUs, and people who
23 are chronically ill or immunocompromised.^{1,3} Physicians and other health care workers play a role
24 in both preventing and transmitting nosocomial infection.

25

26 Health care workers' constant contact with patients and infective material puts them at risk of
27 exposure to and possible transmission of disease, including vaccine-preventable disease.³⁻⁸ Health
28 care workers are at no greater risk of infection than the general population for certain vaccine-
29 preventable diseases (such as tetanus, diphtheria, pneumococcal disease). Some diseases (such as
30 tuberculosis, hepatitis A, meningococcal disease, typhoid fever, vaccinia) put health care workers

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1 at increased risk in certain circumstances (such as outbreaks or when worker has come in direct
2 contact with disease). Still others (such as influenza, hepatitis B, measles, mumps, rubella, and
3 varicella) put health care workers at significant risk of acquiring and transmitting to their patient.⁵
4

5 For vaccine-preventable diseases, the most effective way to reduce transmission from health care
6 worker to patient is immunization.⁸ Immunizing health care workers has the double benefit of
7 directly protecting the health care worker and indirectly protecting the patients with whom they
8 come in contact.^{3,9} For example, studies continue to show that immunizing health care workers for
9 influenza reduces patient morbidity and mortality in both acute and long-term care settings.⁸⁻¹²
10 Immunization also creates herd immunity, protecting patient and health care workers who cannot
11 be vaccinated or for whom vaccine is unlikely to trigger a sufficient antibody response.⁹
12 Immunization helps to maintain the critical workforce during disease outbreaks, during which
13 health care workers are the first line of defense.⁹ In addition, by being vaccinated, physicians and
14 other health care workers set an example to their peers, patients, and the public concerning the
15 importance of immunization.⁹
16

17 Most health care facilities require workers to be vaccinated against varicella, measles, mumps, and
18 rubella.⁹ Health care workers are also expected to take part in comprehensive infection control
19 measures that reduce the risk of infectious disease transmission, including good hand hygiene and
20 respiratory control etiquette and the use of personal protective equipment.⁹
21

22 FUNDAMENTAL ELEMENTS OF IMMUNIZATION POLICIES

23

24 Despite documented benefits for patient safety and efforts by government agencies, regulatory
25 groups, and such professional societies as the AMA to promote influenza vaccination among health
26 care workers, immunization rates remain low—around 40%,^{3,9,13} although there is evidence that
27 immunization rates were higher during the 2009-2010 influenza season.¹⁴ According to the Centers
28 for Disease Control (CDC), the ideal is “vaccination of 100% of employees who do not have
29 medical contraindications.”¹⁵
30

31 A range of options is available to any institution contemplating a vaccine policy, including
32 voluntary immunization, routine universal immunization that permits exemptions on medical or
33 religious or philosophical grounds, or requiring health care workers to be immunized except when
34 that is medically contraindicated. While the CDC acknowledges that policies that work best to
35 achieve this coverage may vary among facilities, studies have demonstrated that coordinated
36 campaigns of education and outreach to address concerns and vaccination can lead to higher rates
37 of immunization among health care workers.¹⁵
38

39 Thus educational programs that center on a message of patient safety can be effective in dispelling
40 myths—for example, that health care workers are not at risk of influenza or that the influenza
41 vaccine is unsafe or ineffective—and increase immunization rates. During the 2009-2010
42 influenza season, Veterans Health Administration health care facilities vaccinated 64% of
43 employees through the system-wide “Infection: Don’t Pass it On” campaign.¹⁶ Strong support
44 from senior medical staff and leaders at health care institutions is also associated with higher
45 acceptance of vaccination among health care workers,^{6,9,17} and convenient access to vaccines
46 provided at no cost has been shown to substantially improve vaccine coverage.^{5,17,18} At a
47 minimum, accredited health care institutions are required by Joint Commission standards to offer
48 influenza vaccination to staff.^{7,9,19}

1 Though controversial, a highly effective approach to achieving high vaccination coverage among
2 health care workers is a mandatory vaccination policy, exempting only those with a medical
3 contraindication.^{9,14} The CDC estimates that in 2009, employer requirements or recommendations
4 for vaccination were associated with an eightfold and fourfold greater likelihood of vaccination for
5 2009 H1N1, respectively.¹⁴ Hospitals and health care systems that have required vaccination of
6 health care workers often have achieved coverage rates of over 90%.⁹

7
8 Efforts to increase vaccination coverage among health care workers using mandatory vaccination
9 policies are supported by various national accrediting and professional organizations, including the
10 World Medical Association, American College of Physicians, Infectious Diseases Society of
11 America, Society for Healthcare Epidemiology of America, National Foundation for Infectious
12 Diseases, National Patient Safety Foundation, and National Quality Forum.^{6,8,9,13,15,20-22} All of these
13 organizations allow exemptions for a medical contraindication,^{6,8,9,13,15,20-22} while only some support
14 exemptions for religious or philosophical objections.^{6,7,9,21}

15
16 Health care institutions and physician groups have begun to implement policies that require
17 influenza vaccination as a condition of employment. For example, BJC Healthcare in St. Louis
18 (BJC) made influenza vaccination a condition of employment prior to the 2008-2009 season—and
19 provided vaccines for free at multiple locations.^{9,23} Those employees who were neither vaccinated
20 nor exempted for medical or religious objections by a certain date were suspended.^{9,23} Those
21 employees who were granted an exemption were encouraged to wear an isolation mask while
22 providing patient care during the flu season.^{9,23} BJC implemented the condition as part of an
23 aggressive patient safety initiative marketed through managers, educational materials, letters to
24 employees, articles on the institution's intranet site, and town hall meetings.^{9,23} As a result, BJC's
25 influenza vaccination rate greatly increased, to 98.4% from less than 80% the previous year.^{9,23}

26
27 Other institutions require immunization for influenza, but allow health care workers to opt out so
28 long as they justify their intent to refrain from vaccination—often in writing—to the institution.
29 Some institutions restrict the patient care activities of employees who have not been immunized for
30 influenza. Some, like Johns Hopkins Health System, have implemented both policies. The health
31 system requires all staff, students, volunteers, and personnel who have direct patient contact to
32 receive the influenza vaccine or complete an online questionnaire identifying their reasons for
33 declining vaccination.²⁰ Vaccinated staff wear a yellow ID badge clip, while nonvaccinated staff
34 must wear a mask when they come within three feet of patients.²⁰

35
36 Pursuant to their power to protect the public health, states have regulations that promote the
37 vaccination of health care workers against influenza.²⁴ The state's power to mandate vaccinations
38 in the interest of the public health has been established since 1905.²⁶ Many states simply require
39 hospitals to have a vaccination policy, some direct health care facilities to offer influenza
40 vaccination to their employees, while still other states require that health care workers receive
41 influenza vaccination or indicate a religious, medical, or philosophic reason for not being
42 vaccinated.²⁶ California, for example, requires employees of general acute care hospitals to be
43 vaccinated annually against influenza or to sign a written declination explaining their refusal,²⁶⁻²⁸
44 while Maine requires designated health facilities to adopt a policy that recommends and offers
45 annual immunization to health care personnel who provide direct care for residents of the facility.²⁶
46 Alabama requires hospitals to establish vaccination requirements for employees that are consistent
47 with current CDC and OSHA recommendations.²⁶

1 ETHICAL CONSIDERATIONS

2
3 Confronting the ethical challenges posed by infectious disease requires physicians to strike a
4 prudent balance among multiple interests and values. Patient welfare, respect for individual
5 liberties and decision-making autonomy, and fair implementation must all play a role in strategies
6 to prevent transmission of disease.

7
8 Primacy of patient interests is one of the cornerstones of medical ethics. As the preamble to the
9 Principles of Medical Ethics notes, as members of the medical profession, physicians “must
10 recognize responsibility to patients first and foremost....” It is also well established that physicians
11 must not place their patients at undue risk of harm,^{15,29} including risk of infectious disease (E-9.13,
12 Physicians and Infectious Diseases [AMA Policy Database]). Physicians’ ethical obligation to
13 subordinate their personal interests to those of patients is even greater in times of health crises,
14 such as epidemic or pandemic (E-9.067, Physician Obligation in Disaster Preparedness and
15 Response).

16
17 Physicians also have well-recognized responsibilities to the community, including the ethical
18 obligation to promote the health of the public (Preamble; Principle VII; E-2.25, The Use of
19 Quarantine and Isolation as Public Health Interventions; E-9.067). Finally, physicians have a
20 responsibility to protect their own health and well-being, grounded in their professional
21 commitment to ensure adequate availability of care¹³ (Principle X; E-9.067).

22
23 These considerations support a professional ethical obligation on the part of physicians to take all
24 reasonable actions to prevent the transmission of disease, including accepting immunization for
25 vaccine-preventable diseases. A variety of factors influence the relative strength of that obligation,
26 such as how readily a given disease is transmitted; the medical risk the disease represents for
27 patients, professional colleagues, and the intimates of all parties; risk of occupational exposure; the
28 safety and efficacy of available vaccine(s); appropriateness and effectiveness of immunization
29 relative to alternative strategies for disease prevention; medical value of vaccination to the
30 individual; and potential contraindications to vaccination for the individual physician or health care
31 worker.

32
33 At the same time, physicians have a right to expect that their personal liberties and autonomy as
34 decision makers will be respected and that they will be treated fairly. For example, the *Code of*
35 *Medical Ethics* recognizes that—within certain limits—physicians may choose whom they will
36 treat and in what environments they will practice medicine. (Principle VI; E-10.05, Potential
37 Patients). Thus physicians should be able to expect that they will not be put at undue or
38 unnecessary risk by being required to accept immunization that is medically contraindicated in
39 their individual circumstances. They should also be able to expect that strongly held personal
40 values will be respected when they decline in good faith to be vaccinated on religious or
41 philosophical grounds.

42
43 But like the responsibility to accept immunization, physicians’ autonomy as individuals is not
44 unlimited. Arguably, in entering the profession of medicine physicians accept certain constraints
45 on their behavior and decisions as individuals in exchange for the privileges of professional status
46 (E-9.067).³⁰ For example, physicians are expected to accept some level of personal risk in
47 providing care for patients (E-9.067; E-9.131, HIV-Infected Patients and Physicians). In the
48 context of preventing the transmission of infectious disease, it is reasonable to require that
49 physicians who decline to be vaccinated take other precautions to protect patients, such as wearing

1 a mask or refraining from close patient contact. Such requirements carry particular weight in the
2 context of highly infective diseases that carry the risk of becoming epidemic or pandemic or that
3 pose significant medical risk to vulnerable populations with whom the physician comes in contact.
4

5 As respected professionals and leaders in health care institutions, physicians are in a position to be
6 role models for the public, their patients, and their colleagues and fellow employees by setting the
7 example of being immunized for vaccine-preventable diseases. Within their institutions, physician-
8 leaders can also take responsibility for promoting immunization policies that are scientifically well
9 grounded, balanced, and procedurally fair. When it has been determined that vaccination will be
10 required absent medical contraindications or religious/philosophical objections, leaders of the
11 medical staff must ensure that there is an appropriate process in place to review an individual
12 physician's justification for declining vaccination and to communicate the individual's decision to
13 colleagues. As we have seen, experience to date indicates that the programs that are most
14 successful in promoting immunization among physicians and other health care workers combine
15 vigorous efforts to educate staff and address concerns and possible misconceptions, strongly
16 promote acceptance of immunization and make it easy for individuals to be vaccinated, and set
17 clear expectations for how unvaccinated individuals will interact with patients. The most
18 successful programs also set meaningful consequences for those who decline to be vaccinated and
19 communicate them clearly.
20

21 As professionals committed to promoting the welfare of individual patients and the health of the
22 public and to safeguarding their own and their colleagues' well-being, physicians have an ethical
23 responsibility to take appropriate measures to prevent the spread of infectious disease. In the
24 context of vaccine-preventable diseases, this includes the obligation to accept immunization, absent
25 contraindication, against highly transmissible diseases that pose significant medical risk to patients,
26 the public, and fellow health care workers. They should expect that when the policies of health
27 care institutions do not recognize refusals of immunization on religious or philosophical grounds,
28 those policies will be transparent and will be communicated to physicians and other staff in
29 advance.
30

31 RECOMMENDATION

32
33 The Council on Ethical and Judicial Affairs recommends that the following be adopted in lieu of
34 Resolution 922-I-09 and Resolution 928-I-09, and that the remainder of this report be filed:
35

36 As professionals committed to promoting the welfare of individual patients and the health of
37 the public and to safeguarding their own and their colleagues' well-being, physicians have an
38 ethical responsibility to take appropriate measures to prevent the spread of infectious disease in
39 health care settings. Conscientious participation in routine infection control practices, such as
40 hand washing and respiratory precautions is a basic expectation of the profession. In some
41 situations, however, routine infection control is not sufficient to protect the interests of patients,
42 the public, and fellow health care workers.
43

44 In the context of a highly transmissible disease that poses significant medical risk for
45 vulnerable patients or colleagues, or threatens the availability of the health care workforce,
46 particularly a disease that has potential to become epidemic or pandemic, and for which there is
47 an available, safe, and effective vaccine, physicians have an obligation to:

- 1 (a) Accept immunization absent a recognized medical, religious, or philosophic reason to not
2 be immunized.
3
- 4 (b) Accept a decision of the medical staff leadership or health care institution, or other
5 appropriate authority to adjust practice activities if not immunized (e.g., wear masks or
6 refrain from direct patient care). It may be appropriate in some circumstances to inform
7 patients about immunization status.
8
- 9 (New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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