“Requiring annual influenza vaccination of health workers against influenza—Why?”

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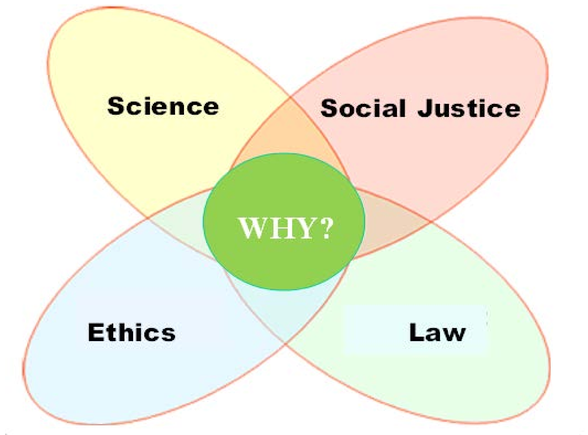
What do ethicists say?

Vaccination is an implied obligation of health care professionals

Necessity of informing patients who are cared for by unvaccinated healthcare worker

Unlikely that voluntary programs be sufficient for obligation of beneficence and nonmaleficence



Carrot or Stick?

A requirement is a carrot!

A requirement is not coercion.

A requirement provides strong incentive.

Not requiring suggests it is not important.

A requirement counters procrastination.

Those who prefer not to get vaccine may limit some of their other options.

What about autonomy?

Primary obligation is to patients; unless exemptions apply, mandates are responsible

Possibility of doing harm overrides principle of autonomy

Prevention of harm to others by spreading infection overrides principle of autonomy

What matters to everyone is intrinsically superior to an individual’s claim of what matters (principle of moral equality).

Patient Safety
Worker Safety
Community Protection

F
A
C
T
S

Influenza causes significant mortality.

Influenza is most frequent and deadliest vaccine-preventable disease in U.S.

Influenza vaccines are safe *and* effective (<0.1% medical complications).

Host is infectious during incubation period.

Asymptomatic host transmits infection.

Health worker transmission to patients has been documented.

25% of healthcare workers may be infected each year.

Mandatory approaches are successful without negative effects.

Education is not enough to change beliefs; knowledge doesn’t ensure healthful behavior.

What are legal issues?

Regulations fundamentally exist for safety of patients.

Nosocomial transmission to a patient presents potential liability for unvaccinated individual who my have transmitted infection, and potential liability to organization for not requiring staff vaccination to ensure patient safety.

What is the evidence?

Despite vigorous education efforts, many staff remain susceptible even though < 0.4% have medical contraindication.

The most successful voluntary programs, using identified best practices, do not achieve and sustain vaccination levels high enough for group protection.

Programs that require signed declination forms have not been effective – neither achieving sufficient vaccination coverage nor staff satisfaction. ACOEM maintains these ‘opt out’ programs inappropriately divert resources.

Institutions that required staff to get seasonal vaccine in 2009-2010 had coverage twice as high as those that recommended vaccination.

Mandatory programs have not reported negative impact on staff morale.

Institutions with successful voluntary programs (i.e., those highly regarded and applauded by NFID, ANA, Joint Commission, et al.) have subsequently implemented requirements to boost coverage to $\geq$ 90%. Without mandates, did *not* achieve goal.

Institutions with vigorous voluntary programs indicate ceiling effect after a couple of years; some report decline.