8.7 Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients.

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

AMA Principles of Medical Ethics: I,II

Background report(s):

CEJA Report 2-I-20 Amendment to Opinion 8.7, Routine universal immunization of physicians

CEJA Report 5-I-10 Routine universal immunization of physicians

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2, November 2020

Subject: Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Growing public skepticism about immunization, falling rates of immunization and the associated resurgence of infectious childhood diseases, and the emergence of new zoonotic diseases that have spread rapidly through human populations underscore the importance of physicians' responsibilities to protect the welfare not only of individual patients, but also of communities. Given heightened awareness of physicians' public health role, the Council on Ethical and Judicial Affairs reviewed ethics guidance set out in Opinion 8.7, "Routine Universal Immunization of Physicians." The following report summarizes the council's deliberations and clarifies its guidance on physicians' responsibility to accept immunization when a safe, effective vaccine is available, especially for a disease that has potential to become epidemic or pandemic.

VACCINATION OF HEALTH CARE WORKERS

Vaccination of health care workers, including physicians, is a logical measure to decrease transmission of vaccine-preventable diseases during patient encounters. Yet despite extensive education on the benefit of vaccination, recommendations from the Society for Healthcare Epidemiology of America [1,2], and strong efforts by health care institutions to promote this preventive measure, rates of vaccination among health care workers can be surprisingly low, especially for seasonal influenza [3].

Requiring vaccination of health care workers does increase vaccination rates for seasonal influenza [3,4]. One multispecialty medical center achieved an influenza vaccination rate of approximately 98 percent among health care workers by requiring vaccination, with exemptions for medical and religious reasons [3]. A study comparing medical centers with and without an influenza vaccine mandate showed a 30 percent difference in vaccination rate between the two groups [4]. The study also found a decrease in days absent for symptomatic influenza-like illness (ILI) for the mandatory vaccination group.

However, the available evidence, most of which comes from observational studies, is mixed regarding the extent to which mandated vaccination of physicians and other health care workers benefits patients [5,6,7]. One meta-analysis of studies from facilities that offered influenza vaccination reported a reduction in all-cause mortality and ILI, but did not show changes in hospitalizations and confirmed cases of influenza [8]. A Cochrane meta-analysis that focused on assessing whether influenza vaccination for health care workers in long-term care institutions similarly did not find significant effect of vaccination in decreasing hospitalizations or confirmed

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cases of influenza among residents [9]. There is a paucity of randomized controlled trials that directly assess the effect of vaccination mandates or campaigns on patient health. One European trial that assessed the impact of a multi-faceted influenza vaccination program for health care workers did find a 5.8 percent reduction in nosocomial cases of influenza and/or pneumonia among hospitalized patients [10].

Critics have observed significant methodological flaws in these studies, including multiple sources of bias and violation of the principle of dilution, casting doubt on the studies' validity [6,7]. This has led proposals for alternatives to mandatory vaccination of health care workers, such as strategies to reduce "presenteeism" (working while ill), which can drastically affect the transmission of influenza [6].

LAW & POLICY

Law and policy throughout the United States require immunizations or other documentation of immunity as a condition of public school attendance and, in some cases, as a condition of employment [11]. Historically, in decisions in *Jacobson v. Massachusetts* [12] and *Zucht v. King* [13], the U.S. Supreme Court has held that states can mandate immunizations to protect public health, but, if they do, they must also allow medical exemptions. Courts have further held that the exemption process must not violate the individual's constitutional rights. Thus, most states must also provide for non-medical exemptions to accommodate religious beliefs of some individuals who oppose immunization [14]. Some states also provide non-medical exemptions for individuals who oppose immunization for personal or philosophical reasons [14].

State laws mandating vaccination of health care workers vary across the country. For example, as of 2017, eight states require that a hospital "ensure" its health care personnel are vaccinated for seasonal influenza; 11 others require only that hospitals "offer" a flu vaccine to their employees [15]. States also vary with respect to whether they recognize exemptions and which exemptions—medical, religious, philosophical—they allow [15].

Employers of health care workers may implement their own mandatory vaccination programs under contractual employment law, as hundreds of facilities around the country have done [16]. Title VII of the Civil Rights Act prohibit religious discrimination and thus requires that employers consider religious exemptions to vaccination and implement such exemptions so as to ensure that any vaccine mandate is nondiscriminatory. Employers must also generally ensure that mandatory vaccination programs allow appropriate medical exemptions for individuals with a disability that would be adversely affected by vaccination [17]. In requiring employers to keep the workplace free of hazards, the Occupational Health and Safety Act may impose a duty on employers to encourage or mandate vaccination to prevent employees from contracting or spreading serious diseases in the workplace [17].

Policies of the AMA House of Delegates generally support physician immunization. H-225.959, Staff Medical Testing, maintains that, when local statute and regulation do not provide for immunization of health care personnel, hospital medical staffs should determine which tests or immunizations are to be required for members of the medical staff and "delineate under what circumstances such tests or immunizations should be administered."

Policy also opposes non-medical exemptions, including non-medical exemptions from mandated pediatric immunizations. H-440.970, Non-Medical Exemptions from Immunization, supports eliminating non-medical exemptions from immunization and encourage physicians to grant exemption requests "only when medical contraindications are present." AMA policy further

supports restricting the activity of medical staff who are not immunized. In the specific context of Hepatitis B, for example, H-440.949, Immunity to Hepatitis B Virus, requires that medical staff who do not have immunity from a natural infection or who have not been immunized, "either be immunized or refrain from performing invasive procedures."

PHYSICIANS' ETHICAL RESPONSIBILITIES

Physicians have well-recognized professional responsibilities to protect the health of their individual patients (Principle VIII, Opinion 8.11, "Health Promotion and Disease Prevention"). They also have responsibilities to protect the health of the community at large (Principle VII, Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness"). And they have an obligation to protect their own health and that of their colleagues and other members of the health care workforce (Principle X, Opinion 9.3.1, "Physician Health and Wellness"; Opinion 8.3; Opinion 8.4, "Ethical Use of Quarantine and Isolation").

Responsibility to Protect

In the context of a health care crisis—e.g., epidemic, disaster, or terrorism—physicians' ethical obligation is to subordinate their personal interests to those of their patients. Their first duty, set out in Opinion 8.3, is to "provide urgent medical care . . . even in the face of greater than usual risk to physicians' own safety, health or life." Opinion 8.3 recognizes that the physician workforce itself is not an unlimited resource, however. Thus, physicians are expected to assess the risks of providing care to individual patients in the moment against the ability to provide care in the future. Opinion 8.4 similarly requires physicians to "protect their own health to ensure that they remain able to provide care."

Taken together, these considerations argue strongly for a responsibility on the part of physicians to accept immunization against vaccine-preventable diseases—unless there are compelling reasons for the individual not to receive a specific vaccine. Medical exemptions from vaccination are intended to prevent harm to individuals who are at increased risk of adverse events from the vaccine because of underlying conditions. Vaccines are medically contraindicated for individuals who have histories of severe allergic reactions from prior doses of vaccine. Many underlying conditions also place individuals at increased risk of complications from certain vaccines as well as from the diseases they prevent. For example, individuals who are severely immunocompromised should not be inoculated with vaccines containing live attenuated viruses, such as the varicella zoster (chicken pox or shingles) or measles, mumps, and rubella (MMR) vaccines [18]. Individuals for whom vaccines are medically contraindicated are protected from exposure to vaccine-preventable diseases through herd immunity by ensuring high rates of coverage among the rest of the population.

The relative strength of the responsibility to accept vaccination is conditioned on several factors, including how readily a given disease is transmitted; what medical risk the disease represents for patients, colleagues, and society; the individual's risk of occupational exposure; the safety and efficacy of available vaccine(s); the effectiveness and appropriateness of immunization relative to other strategies for preventing disease transmission; the medical value or possible contraindication of immunization for the individual [19], and the prevalence of the disease. Unless medically contraindicated, the more readily transmissible the disease and the greater the risk to patients and others with whom the physician comes into contact relative to risks of immunization to the physician, the stronger the physician's duty to accept immunization. Physicians should not be required to accept immunization with a novel agent until and unless there is a body of scientifically well-regarded evidence of safety and efficacy.

It is not ethically problematic to exempt from vaccination an individual with medical contraindications. Ethical concerns arise when individuals are allowed to decline vaccinations for non-medical reasons. The rationale for non-medical exemptions must strike a prudent balance among multiple interests and values, including the welfare of individuals, groups and communities; respect for civil liberties and autonomy; and fairness.

In general, society respects individuals' freedom to make health care decisions for themselves in keeping with their religious commitments, and within limits, decisions based on personal beliefs that are not encoded in specific religious doctrine per se. Ideally, those beliefs will comprise a "substantive, coherent, and relatively stable set of values and principles" to which the individual is genuinely committed and that are reflected broadly in the individual's decisions and actions [20].

Individuals who have direct patient contact should rightly expect their autonomy to be respected when their personal health choices do not put others at risk of harm [21]. In certain circumstances physicians should refrain from being immunized in order to protect the well-being of their patients; for example, if receiving a live virus vaccine would put immune-compromised or never-immunized patients at risk during the time the physician may transmit the attenuated virus.

Aside from these limited circumstances, however, physicians and other health care workers who decline to be vaccinated do put others at risk for vaccine-preventable disease. In deciding whether to decline vaccination, therefore, physicians have a responsibility to strike an ethically acceptable balance between their personal commitments as moral individuals and their obligations as medical professionals. Those who cannot or choose not to be immunized when a safe, effective, and well-tested vaccine is available must take other steps to protect themselves and those to whom they may transmit a vaccine-preventable disease, which may include refraining from patient contact.

Arguably, physicians' responsibility to protect patients' well-being extends to ensuring that all staff in their own practices are vaccinated, absent medical contraindication; when they or their staff are not immunized, physicians must protect themselves and patients in other ways. At a minimum, physician-leaders in practices and health organizations should require that staff who come into contact with high-risk patients take appropriate protective measures.

Responsibility to Promote Shared Decision Making

As trusted sources of information and guidance, physicians can play a significant role in shaping their patients' perspectives about vaccines and the decisions patients make about immunizing themselves and their families [22-27]. In keeping with practices recognized for increasing uptake of childhood immunizations, physicians have a responsibility to educate patients about the risks of forgoing or delaying a recommended immunization [28]. Exploring with vaccine hesitant patients their reasons for declining recommended immunizations is crucial. Vaccine hesitant patients commonly misunderstand physicians' motivation for urging immunization, but when reminded that their physician is motivated first and foremost by their welfare instead of public health concerns are more receptive to considering immunization [28]. Candor, willingness to listen, encouraging questions, and respectfully acknowledging patients'—or parents—concerns are essential elements of conversations with vaccine-hesitant individuals [28].

Physicians also serve as role models for their patients, consciously or otherwise. Physicians who adhere to immunization requirements and recommendations for themselves and their children can be powerful motivators for patients, colleagues, and others in the community to pursue immunization [2]. Physicians can take advantage of their power to motivate by communicating that

they themselves have been immunized. By the same token, physicians who fail to follow their own advice risk compromising patients' trust and undermining their credibility as advisors.

RESPONSIBILITIES OF HEALTH CARE INSTITUTIONS

Medicine is fundamentally a moral activity, and as sites in which that activity is carried out, health care institutions share the profession's "commitment to fidelity and service" [29]. They have obligations to the communities of patients the institution serves, to the physicians and other health care professionals who provide hands-on care, and to the other personnel who support those activities. Opinion 11.2.6, "Mergers of Secular and Religiously Affiliated Institutions," holds that "[p]rotecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it" is an essential responsibility.

Health care institutions discharge this responsibility by proactively developing policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedure should include robust infection control practices, providing appropriate protective equipment, and a program for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of their staff. Health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from patient care activities or other direct patient contact.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and deletion as follows and that the remainder of this report be filed:

> As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.
>
> In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians ~~should:~~
>
> ~~Accept~~ have a responsibility to accept immunization absent a recognized medical~~, religious, or philosophic reason to not be immunized~~ contraindication or when a specific vaccine would pose a significant risk to the physician's patients.
>
> ~~(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain~~

~~from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.~~

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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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

Presented by: John W. McMahon, Sr., MD, Chair

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

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

INFECTIOUS DISEASE & PATIENT WELFARE

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

Health care workers' constant contact with patients and infective material puts them at risk of exposure to and possible transmission of disease, including vaccine-preventable disease.[3-8] Health care workers are at no greater risk of infection than the general population for certain vaccine-preventable diseases (such as tetanus, diphtheria, pneumococcal disease). Some diseases (such as tuberculosis, hepatitis A, meningococcal disease, typhoid fever, vaccinia) put health care workers at increased risk in certain circumstances (such as outbreaks or when worker has come in direct

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contact with disease). Still others (such as influenza, hepatitis B, measles, mumps, rubella, and varicella) put health care workers at significant risk of acquiring and transmitting to their patient.[5]

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

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

FUNDAMENTAL ELEMENTS OF IMMUNIZATION POLICIES

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

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

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

Though controversial, a highly effective approach to achieving high vaccination coverage among health care workers is a mandatory vaccination policy, exempting only those with a medical contraindication.[9,14] The CDC estimates that in 2009, employer requirements or recommendations

for vaccination were associated with an eightfold and fourfold greater likelihood of vaccination for 2009 H1N1, respectively.[14] Hospitals and health care systems that have required vaccination of health care workers often have achieved coverage rates of over 90%.[9]

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

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

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

Pursuant to their power to protect the public health, states have regulations that promote the vaccination of health care workers against influenza.[24] The state's power to mandate vaccinations in the interest of the public health has been established since 1905.[26] Many states simply require hospitals to have a vaccination policy, some direct health care facilities to offer influenza vaccination to their employees, while still other states require that health care workers receive influenza vaccination or indicate a religious, medical, or philosophic reason for not being vaccinated.[26] California, for example, requires employees of general acute care hospitals to be vaccinated annually against influenza or to sign a written declination explaining their refusal,[26-28] while Maine requires designated health facilities to adopt a policy that recommends and offers annual immunization to health care personnel who provide direct care for residents of the facility.[26] Alabama requires hospitals to establish vaccination requirements for employees that are consistent with current CDC and OSHA recommendations.[26]

ETHICAL CONSIDERATIONS

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

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

Physicians also have well-recognized responsibilities to the community, including the ethical obligation to promote the health of the public (Preamble; Principle VII; E-2.25, The Use of Quarantine and Isolation as Public Health Interventions; E-9.067). Finally, physicians have a responsibility to protect their own health and well-being, grounded in their professional commitment to ensure adequate availability of care[13] (Principle X; E-9.067).

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

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

But like the responsibility to accept immunization, physicians' autonomy as individuals is not unlimited. Arguably, in entering the profession of medicine physicians accept certain constraints on their behavior and decisions as individuals in exchange for the privileges of professional status (E-9.067).[30] For example, physicians are expected to accept some level of personal risk in providing care for patients (E-9.067; E-9.131, HIV-Infected Patients and Physicians). In the context of preventing the transmission of infectious disease, it is reasonable to require that physicians who decline to be vaccinated take other precautions to protect patients, such as wearing a mask or refraining from close patient contact. Such requirements carry particular weight in the context of highly infective diseases that carry the risk of becoming epidemic or pandemic or that pose significant medical risk to vulnerable populations with whom the physician comes in contact.

As respected professionals and leaders in health care institutions, physicians are in a position to be role models for the public, their patients, and their colleagues and fellow employees by setting the example of being immunized for vaccine-preventable diseases. Within their institutions, physician-leaders can also take responsibility for promoting immunization policies that are scientifically well grounded, balanced, and procedurally fair. When it has been determined that vaccination will be

required absent medical contraindications or religious/philosophical objections, leaders of the medical staff must ensure that there is an appropriate process in place to review an individual physician's justification for declining vaccination and to communicate the individual's decision to colleagues. As we have seen, experience to date indicates that the programs that are most successful in promoting immunization among physicians and other health care workers combine vigorous efforts to educate staff and address concerns and possible misconceptions, strongly promote acceptance of immunization and make it easy for individuals to be vaccinated, and set clear expectations for how unvaccinated individuals will interact with patients. The most successful programs also set meaningful consequences for those who decline to be vaccinated and communicate them clearly.

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

RECOMMENDATION

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

> As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to take appropriate measures to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.
>
> In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have an obligation to:
>
> (a) Accept immunization absent a recognized medical, religious, or philosophic reason to not be immunized.
>
> (b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.

(New HOD/CEJA Policy)

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

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