

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”

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Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

10 11 VACCINATION OF HEALTH CARE WORKERS

12
13 Vaccination of health care workers, including physicians, is a logical measure to decrease
14 transmission of vaccine-preventable diseases during patient encounters. Yet despite extensive
15 education on the benefit of vaccination, recommendations from the Society for Healthcare
16 Epidemiology of America [1,2], and strong efforts by health care institutions to promote this
17 preventive measure, rates of vaccination among health care workers can be surprisingly low,
18 especially for seasonal influenza [3].

19
20 Requiring vaccination of health care workers does increase vaccination rates for seasonal influenza
21 [3,4]. One multispecialty medical center achieved an influenza vaccination rate of approximately
22 98 percent among health care workers by requiring vaccination, with exemptions for medical and
23 religious reasons [3]. A study comparing medical centers with and without an influenza vaccine
24 mandate showed a 30 percent difference in vaccination rate between the two groups [4]. The study
25 also found a decrease in days absent for symptomatic influenza-like illness (ILI) for the mandatory
26 vaccination group.

27
28 However, the available evidence, most of which comes from observational studies, is mixed
29 regarding the extent to which mandated vaccination of physicians and other health care workers
30 benefits patients [5,6,7]. One meta-analysis of studies from facilities that offered influenza
31 vaccination reported a reduction in all-cause mortality and ILI, but did not show changes in
32 hospitalizations and confirmed cases of influenza [8]. A Cochrane meta-analysis that focused on
33 assessing whether influenza vaccination for health care workers in long-term care institutions
34 similarly did not find significant effect of vaccination in decreasing hospitalizations or confirmed

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

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

12
 13 **LAW & POLICY**

14
 15 Law and policy throughout the United States require immunizations or other documentation of
 16 immunity as a condition of public school attendance and, in some cases, as a condition of
 17 employment [11]. Historically, in decisions in *Jacobson v. Massachusetts* [12] and *Zucht v. King*
 18 [13], the U.S. Supreme Court has held that states can mandate immunizations to protect public
 19 health, but, if they do, they must also allow medical exemptions. Courts have further held that the
 20 exemption process must not violate the individual's constitutional rights. Thus, most states must
 21 also provide for non-medical exemptions to accommodate religious beliefs of some individuals
 22 who oppose immunization [14]. Some states also provide non-medical exemptions for individuals
 23 who oppose immunization for personal or philosophical reasons [14].

24
 25 State laws mandating vaccination of health care workers vary across the country. For example, as
 26 of 2017, eight states require that a hospital "ensure" its health care personnel are vaccinated for
 27 seasonal influenza; 11 others require only that hospitals "offer" a flu vaccine to their employees
 28 [15]. States also vary with respect to whether they recognize exemptions and which exemptions—
 29 medical, religious, philosophical—they allow [15].

30
 31 Employers of health care workers may implement their own mandatory vaccination programs
 32 under contractual employment law, as hundreds of facilities around the country have done [16].
 33 Title VII of the Civil Rights Act prohibit religious discrimination and thus requires that employers
 34 consider religious exemptions to vaccination and implement such exemptions so as to ensure that
 35 any vaccine mandate is nondiscriminatory. Employers must also generally ensure that mandatory
 36 vaccination programs allow appropriate medical exemptions for individuals with a disability that
 37 would be adversely affected by vaccination [17]. In requiring employers to keep the workplace free
 38 of hazards, the Occupational Health and Safety Act may impose a duty on employers to encourage
 39 or mandate vaccination to prevent employees from contracting or spreading serious diseases in the
 40 workplace [17].

41
 42 Policies of the AMA House of Delegates generally support physician immunization. [H-225.959](#),
 43 Staff Medical Testing, maintains that, when local statute and regulation do not provide for
 44 immunization of health care personnel, hospital medical staffs should determine which tests or
 45 immunizations are to be required for members of the medical staff and "delineate under what
 46 circumstances such tests or immunizations should be administered."

47
 48 Policy also opposes non-medical exemptions, including non-medical exemptions from mandated
 49 pediatric immunizations. [H-440.970](#), Non-Medical Exemptions from Immunization, supports
 50 eliminating non-medical exemptions from immunization and encourage physicians to grant
 51 exemption requests "only when medical contraindications are present." AMA policy further

1 supports restricting the activity of medical staff who are not immunized. In the specific context of
 2 Hepatitis B, for example, [H-440.949](#), Immunity to Hepatitis B Virus, requires that medical staff
 3 who do not have immunity from a natural infection or who have not been immunized, “either be
 4 immunized or refrain from performing invasive procedures.”

5
 6 PHYSICIANS’ ETHICAL RESPONSIBILITIES

7
 8 Physicians have well-recognized professional responsibilities to protect the health of their
 9 individual patients ([Principle VIII](#), [Opinion 8.11](#), “Health Promotion and Disease Prevention”).
 10 They also have responsibilities to protect the health of the community at large ([Principle VII](#),
 11 [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness”). And they
 12 have an obligation to protect their own health and that of their colleagues and other members of the
 13 health care workforce ([Principle X](#), [Opinion 9.3.1](#), “Physician Health and Wellness”; [Opinion 8.3](#);
 14 [Opinion 8.4](#), “Ethical Use of Quarantine and Isolation”).

15
 16 *Responsibility to Protect*

17
 18 In the context of a health care crisis—e.g., epidemic, disaster, or terrorism—physicians’ ethical
 19 obligation is to subordinate their personal interests to those of their patients. Their first duty, set out
 20 in [Opinion 8.3](#), is to “provide urgent medical care . . . even in the face of greater than usual risk to
 21 physicians’ own safety, health or life.” [Opinion 8.3](#) recognizes that the physician workforce itself is
 22 not an unlimited resource, however. Thus, physicians are expected to assess the risks of providing
 23 care to individual patients in the moment against the ability to provide care in the future. [Opinion](#)
 24 [8.4](#) similarly requires physicians to “protect their own health to ensure that they remain able to
 25 provide care.”

26
 27 Taken together, these considerations argue strongly for a responsibility on the part of physicians to
 28 accept immunization against vaccine-preventable diseases—unless there are compelling reasons for
 29 the individual not to receive a specific vaccine. Medical exemptions from vaccination are intended
 30 to prevent harm to individuals who are at increased risk of adverse events from the vaccine because
 31 of underlying conditions. Vaccines are medically contraindicated for individuals who have
 32 histories of severe allergic reactions from prior doses of vaccine. Many underlying conditions also
 33 place individuals at increased risk of complications from certain vaccines as well as from the
 34 diseases they prevent. For example, individuals who are severely immunocompromised should not
 35 be inoculated with vaccines containing live attenuated viruses, such as the varicella zoster (chicken
 36 pox or shingles) or measles, mumps, and rubella (MMR) vaccines [18]. Individuals for whom
 37 vaccines are medically contraindicated are protected from exposure to vaccine-preventable diseases
 38 through herd immunity by ensuring high rates of coverage among the rest of the population.

39
 40 The relative strength of the responsibility to accept vaccination is conditioned on several factors,
 41 including how readily a given disease is transmitted; what medical risk the disease represents for
 42 patients, colleagues, and society; the individual’s risk of occupational exposure; the safety and
 43 efficacy of available vaccine(s); the effectiveness and appropriateness of immunization relative to
 44 other strategies for preventing disease transmission; the medical value or possible contraindication
 45 of immunization for the individual [19], and the prevalence of the disease. Unless medically
 46 contraindicated, the more readily transmissible the disease and the greater the risk to patients and
 47 others with whom the physician comes into contact relative to risks of immunization to the
 48 physician, the stronger the physician’s duty to accept immunization. Physicians should not be
 49 required to accept immunization with a novel agent until and unless there is a body of scientifically
 50 well-regarded evidence of safety and efficacy.

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

6
7 In general, society respects individuals' freedom to make health care decisions for themselves in
8 keeping with their religious commitments, and within limits, decisions based on personal beliefs
9 that are not encoded in specific religious doctrine per se. Ideally, those beliefs will comprise a
10 "substantive, coherent, and relatively stable set of values and principles" to which the individual is
11 genuinely committed and that are reflected broadly in the individual's decisions and actions [20].
12

13 Individuals who have direct patient contact should rightly expect their autonomy to be respected
14 when their personal health choices do not put others at risk of harm [21]. In certain circumstances
15 physicians should refrain from being immunized in order to protect the well-being of their patients;
16 for example, if receiving a live virus vaccine would put immune-compromised or never-immunized
17 patients at risk during the time the physician may transmit the attenuated virus.
18

19 Aside from these limited circumstances, however, physicians and other health care workers who
20 decline to be vaccinated do put others at risk for vaccine-preventable disease. In deciding whether
21 to decline vaccination, therefore, physicians have a responsibility to strike an ethically acceptable
22 balance between their personal commitments as moral individuals and their obligations as medical
23 professionals. Those who cannot or choose not to be immunized when a safe, effective, and well-
24 tested vaccine is available must take other steps to protect themselves and those to whom they may
25 transmit a vaccine-preventable disease, which may include refraining from patient contact.
26

27 Arguably, physicians' responsibility to protect patients' well-being extends to ensuring that all staff
28 in their own practices are vaccinated, absent medical contraindication; when they or their staff are
29 not immunized, physicians must protect themselves and patients in other ways. At a minimum,
30 physician-leaders in practices and health organizations should require that staff who come into
31 contact with high-risk patients take appropriate protective measures.
32

33 *Responsibility to Promote Shared Decision Making*

34

35 As trusted sources of information and guidance, physicians can play a significant role in shaping
36 their patients' perspectives about vaccines and the decisions patients make about immunizing
37 themselves and their families [22-27]. In keeping with practices recognized for increasing uptake
38 of childhood immunizations, physicians have a responsibility to educate patients about the risks of
39 forgoing or delaying a recommended immunization [28]. Exploring with vaccine hesitant patients
40 their reasons for declining recommended immunizations is crucial. Vaccine hesitant patients
41 commonly misunderstand physicians' motivation for urging immunization, but when reminded that
42 their physician is motivated first and foremost by their welfare instead of public health concerns are
43 more receptive to considering immunization [28]. Candor, willingness to listen, encouraging
44 questions, and respectfully acknowledging patients'—or parents—concerns are essential elements
45 of conversations with vaccine-hesitant individuals [28].
46

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

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

3
4 RESPONSIBILITIES OF HEALTH CARE INSTITUTIONS

5
6 Medicine is fundamentally a moral activity, and as sites in which that activity is carried out, health
7 care institutions share the profession's "commitment to fidelity and service" [29]. They have
8 obligations to the communities of patients the institution serves, to the physicians and other health
9 care professionals who provide hands-on care, and to the other personnel who support those
10 activities. [Opinion 11.2.6](#), "Mergers of Secular and Religiously Affiliated Institutions," holds that
11 "[p]rotecting the community that the institution serves as well as the integrity of the institution, the
12 physicians and other professionals who practice in association with it" is an essential responsibility.

13
14 Health care institutions discharge this responsibility by proactively developing policies and
15 procedures for responding to epidemic or pandemic disease with input from practicing physicians,
16 institutional leadership, and appropriate specialists. Such policies and procedure should include
17 robust infection control practices, providing appropriate protective equipment, and a program for
18 making appropriate immunization readily available to staff. During outbreaks of vaccine-
19 preventable disease for which there is a safe, effective vaccine, institutions' responsibility may
20 extend to requiring immunization of their staff. Health care institutions have a further responsibility
21 to limit patient and staff exposure to individuals who are not immunized, which may include
22 requiring unimmunized individuals to refrain from patient care activities or other direct patient
23 contact.

24
25 RECOMMENDATION

26
27 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that
28 Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and
29 deletion as follows and that the remainder of this report be filed:

30
31 As professionals committed to promoting the welfare of individual patients and the health of
32 the public and to safeguarding their own and their colleagues' well-being, physicians have an
33 ethical responsibility to encourage patients to accept immunization when the patient can do so
34 safely, and to take appropriate measures in their own practice to prevent the spread of
35 infectious disease in health care settings. Conscientious participation in routine infection
36 control practices, such as hand washing and respiratory precautions is a basic expectation of
37 the profession. In some situations, however, routine infection control is not sufficient to protect
38 the interests of patients, the public, and fellow health care workers.

39
40 In the context of a highly transmissible disease that poses significant medical risk for
41 vulnerable patients or colleagues, or threatens the availability of the health care workforce,
42 particularly a disease that has potential to become epidemic or pandemic, and for which there is
43 an available, safe, and effective vaccine, physicians ~~should:~~

44
45 ~~Accept~~ have a responsibility to accept immunization absent a recognized medical, religious, or
46 ~~philosophic reason to not be immunized~~ contraindication or when a specific vaccine would
47 pose a significant risk to the physician's patients.

48
49 ~~(b) Accept a decision of the medical staff leadership or health care institution, or other~~
50 ~~appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain~~

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

3
4 Physicians who are not or cannot be immunized have a responsibility to voluntarily take
5 appropriate action to protect patients, fellow health care workers and others. They must adjust
6 their practice activities in keeping with decisions of the medical staff, institutional policy, or
7 public health policy, including refraining from direct patient contact when appropriate.

8
9 Physician practices and health care institutions have a responsibility to proactively develop
10 policies and procedures for responding to epidemic or pandemic disease with input from
11 practicing physicians, institutional leadership, and appropriate specialists. Such policies and
12 procedures should include robust infection control practices, provision and required use of
13 appropriate protective equipment, and a process for making appropriate immunization readily
14 available to staff. During outbreaks of vaccine-preventable disease for which there is a safe,
15 effective vaccine, institutions' responsibility may extend to requiring immunization of staff.
16 Physician practices and health care institutions have a further responsibility to limit patient and
17 staff exposure to individuals who are not immunized, which may include requiring
18 unimmunized individuals to refrain from direct patient contact.

19
20 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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