

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Monique A. Spillman, MD, Chair:

1. PHYSICIAN COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

HOD ACTION: **FILED**
 See Opinion 8.1.3

INTRODUCTION

At the 2019 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-19, “Competence, Self-Assessment and Self-Awareness.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.1.3 – Physician Competence, Self-Assessment and Self-Awareness

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

- (a) Cultivate continuous self-awareness and self-observation.
- (b) Recognize that different points of transition in professional life can make different demands on competence.
- (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.
- (d) Seek feedback from peers and others.
- (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.
- (f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.
- (g) Intervene in a timely, appropriate, and compassionate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment. (I, VII, VIII)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Monique A. Spillman, MD, Chair:

1. AMENDMENT TO OPINION 1.2.2, “DISRUPTIVE BEHAVIOR AND DISCRIMINATION BY PATIENTS”

HOD ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Opinion 1.2.2, Policy D-65.991

Policy D-65.991, “Discrimination against Physicians by Patients,” directs the American Medical Association (AMA) to study: “(1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients’ requests; (2) hospitals’ and other health care systems’ policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests.”

The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics concerns in this area and offers guidance for physicians when they encounter patients who refuse or demand care based on what the patient perceives to be the physician’s personal, rather than professional, characteristics. The Council recognizes that surrogates and family members may also engage in conduct that is disrespectful, derogatory or prejudiced but focuses here on such conduct directed toward physicians in light of physicians’ unique fiduciary obligations to patients. Based on its deliberations and review of relevant literature, CEJA recommends that D-65.991 be addressed by amending Opinion 1.2.2, “Disruptive Behavior by Patients.”

REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE

It is not known how often patients discriminate against or sexually harass physicians (and other health care personnel) as data are not systematically collected or publicly reported. However, a growing number of studies and an expanding body of anecdotal reports suggest that such behavior is pervasive in health U.S. care [e.g., 1–7]. In the words of one analyst discrimination by patients is medicine’s “open secret” [4].

A survey of physicians conducted jointly by Medscape and WebMD in 2017 found that 59% of respondents overall heard an offensive remark from a patient about the physician’s personal characteristic, including comments about the physician’s weight and political views in addition to comments about age, ethnicity or national origin, gender, race, and sexual orientation [8]. Emergency physicians were significantly more likely to report having experienced bias (83%) than primary care physicians (62%) or specialists (59%). Among respondents, more African American (70%), Asian (69%), and Hispanic (63%) physicians reported hearing biased comments compared to white physicians (55%). The same survey found that male and female physicians experience bias differently, notably in terms of the physician characteristics targeted. For example, female respondents reported experiencing bias more often on the basis of their gender or age than male physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced bias based on their ethnicity or religion somewhat more often than their female colleagues (24% versus 20% and 15% versus 8%, respectively) [8].

A variety of factors can result in patient behavior that is disrespectful, derogatory, or prejudiced, including mental illness or incapacity or individual life experience, as well as personal beliefs and bias. Different factors carry different implications for whether, or to what degree, patients can reasonably be held responsible for their problematic behavior. It would not be appropriate to hold patients responsible or blameworthy for statements or actions that are beyond their control in the moment [9]. Thus, physicians’ first response to problematic behavior should be to explore insofar as possible the reasons underlying the behavior so that they can identify, appreciate, and address potentially treatable conditions. Behavior that outright threatens the safety of health care personnel or other patients calls for prompt action to de-escalate the situation or remove the threat [e.g., 10, 11].

Lingering systemic racism and health disparities in the United States shape the experience of both patients and health care professionals, especially those from nondominant communities [1, 3, 12]. Against this background, patients’ reasons for refusing care by a specific physician or requesting a different physician cover a “spectrum of justifiability” [13].

Requests not to be treated by a specific physician may reflect fears or concerns about care that are rooted in systemic discrimination against members of the patient's community or traumatic experiences in a patient's personal history [4, 9, 13]. Requests *for* a physician concordant in ethnicity, religion, or gender may reflect cultural preferences or traditions, for example, a Muslim woman's preference to receive care from a female physician. Such requests may also reflect patients' experience, or reasonable expectation, that they will be better understood by a physician "like them." Evidence suggests that at least for some patients, racial/ethnic or cultural concordance between patient and physician supports more effective communication, enhances satisfaction, and may have clinical benefit [4]. In these situations, it is appropriate to respect patient concerns and preferences, when doing so is clinically feasible.

Requests for an alternative physician based solely on prejudice against personal characteristics of the physician, however, are not justifiable and need not—perhaps should not—be accommodated [4, 9, 13]. Requests based on a physician's (actual or perceived) race, ethnicity or national origin, creed, gender identity, sexual orientation, disability, or other personal characteristic are ethically objectionable.

For physicians and health care institutions faced with patients' strongly held views about who should provide care, then, a central task is distinguishing when a patient's stated preference rests on ethically acceptable reasons and when it reflects unacceptable bias or prejudice [2, 9]. One challenge in making such an assessment, of course, is that in some situations time constraints or other factors may preclude being able to explore the factors that influence a patient's behavior.

PROTECTING INTERESTS, MINIMIZING HARMS

Patient refusals of care or demands for an alternative clinician challenge physicians, and the institutions in which they work, to protect both the interests of patients and those of physicians. In such situations, physicians' professional obligations to promote patient well-being, respect patients as moral agents and autonomous decision makers, and fulfill the duty to treat without discrimination come into tension in potentially novel ways. Nor do these responsibilities align with physicians' own interests in upholding professional autonomy and themselves being free from discrimination. There are potential harms to both parties whether the physician/institution accommodates bigoted requests and removes the physician or requires patient and physician to engage one another in a troubled relationship.

Physicians' fiduciary obligations are fundamental. Physicians are expected to promote patients' interests and well-being without regard to individuals' personal characteristics or behavior, up to and including providing care to individuals whose behavior may be morally repugnant [13, 14]. But whether continuing to provide care or allowing oneself to be withdrawn from a case better fulfills that fiduciary obligation is only intelligible in the individual case. So too are interpretations of how a physician is to respect the autonomy of a patient who asserts moral agency in the form of prejudice, and what the duty to care entails when the recipient behaves in a way that, arguably, is not morally worthy or acceptable. Reaching sound determinations in these matters cannot be done by rote; instead, as one commentator observed, doing so calls for "nuanced ethical judgment" [13].

The American Medical Association *Code of Medical Ethics* enjoins physicians to provide "competent medical care, with compassion and respect for human dignity and rights" [15]. It also acknowledges that, except in emergencies, physicians shall be "free to choose whom to serve" [16].

The *Code* further delineates the conditions under which a physician may decline to accept a new patient (or provide a specific service to an existing patient [17]). These include when the care requested is outside the physician's competence or scope of practice; when the physician lacks the resources to provide safe, competent, respectful care for the individual; and when meeting this patient's medical needs seriously compromises the physician's ability to provide the care needed by other patients. Importantly, guidance acknowledges that, except in emergencies, a physician may decline to provide care when the patient "is abusive or threatens the physician, staff, or other patients" [17]. At the same time, the *Code* provides that physicians may terminate a relationship with a patient who "uses derogatory language or acts in a prejudicial manner *only if the patient will not modify the behavior*," in which case the physician should arrange to transfer the patient's care [emphasis added] [18].

One approach to determining the ethically appropriate response to prejudiced behavior by patients is to explore the harms—to patients, to physicians and other health care professionals, and to health care institutions and even the wider community—that can result from different possible responses. Who, that is, is harmed by a given response, and in what way?

Thwarting the requests of seemingly bigoted patients for alternative clinicians exposes patients to possible delays in care and poorer health outcomes, should they choose to leave the facility (with or without assistance from the institution). If they do not, or cannot leave, patients are subjected to the experience of receiving medical care from a physician against whom they are biased. Distinguishing between a preference for a different physician and a demand for one is important in thinking about the nature and degree of harm the patient may experience. A preference is “an expression of an inclination that may be gratified or not”; a demand is “more of an ultimatum, in which failure to meet its indicia may be met not only with disappointment but also anger and resentment” [9]. Further, it is important to determine why the patient is making the request/demand, which may have a clinical source, such as delirium, dementia, or psychosis [4, 13], that is outside the patient’s control, as opposed to being a stance the patient has voluntarily adopted. And as noted previously, requests/demands may also reflect life experiences that color a patient’s response to clinicians for which accommodation may be appropriate.

For physicians and other clinicians, acceding to bigoted demands can send powerful, but unintended and potentially hurtful messages—that minority or female physicians are “not as good” as white male physicians or that patient satisfaction scores are more important to the institution than promoting a safe and ethical working environment [1, 19]. Accommodating bigotry can make institutions complicit in discrimination [19], in the process tacitly condoning or reinforcing an institutional culture that routinely subjects minority physicians to “barrages of microaggressions and biases” or expects them to serve as “race/ethnicity ambassadors” [1].

Institutions that fail to support staff in the face of prejudice convey that complying with patient demands “is more important than respecting the dignity of both their staff members and the majority of patients, who do not hold such repugnant views (or at least do not openly act on them)” [9]. Institutions, some argue, “have a duty to present a moral face to their community by refusing to honor bigoted or prejudicial requests or demands as a matter of course, up to and including declining to care for such patients (except in emergency situations)” [9, cp. 20].

Regardless of how their institutions respond, for many minority health care professionals, interactions with prejudiced patients are painful and degrading and contribute to moral distress and burnout [4]. *Requiring* physicians to provide care when a patient has openly expressed bias is not ethically tenable. As one physician described his own experience of ultimately declining to work with a particular patient, “After years of feeling that my race was a nonissue, I was subjected to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not having thicker skin began to creep in, I decided that, on this occasion, my feelings would count” [21]. Absent unique situations, institutions should allow physicians to control the decision about whether they will continue to provide care [19]. Some have argued that institutions have a responsibility to monitor such encounters and their effects on an ongoing basis “with the goal of supporting staff and improving the handling of these situations” [4].

Whether patient prejudice against physicians adversely affects quality of care has not been well studied. One experimental study among family practice physicians in the Netherlands concluded that “disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors” [22]. A companion study attributed this to the fact that the “mental resources” devoted to dealing with patient behavior interfered with “adequate processing of clinical findings” [23]. Evidence does indicate that physician “burnout” can adversely affect patient outcomes [e.g., 24–26]. To the extent that being the target of patient prejudice contributes to the emotional exhaustion, sense of depersonalization, and sense of low personal accomplishment characteristic of burnout, it is reasonable to expect biased behavior to be associated with lower quality of care, particularly if targeted physicians feel they do not have the support of their colleagues or institutions when bias occurs [1, 21, 27, 28].

LAW AND POLICY

Legally, at the federal level how a health care institution responds to prejudiced behavior by patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act* (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA). For example, when weighing patient requests for accommodation based on the physician’s race, hospitals are in the position of having to meet EMTALA requirements while respecting physicians’ employment rights [4]. Hospitals can “inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful speech,” but their ability “to remove physicians in response to race-based requests is circumscribed” [4]. Although physicians have not sued under CRA [4], in a case that ultimately settled, an African-American nurse in Michigan sued her employer when she was barred from caring for a white baby at the request of the child’s father, a white supremacist [29].

At present, relatively few institutions have formal policy or procedures for dealing with incidents of patient prejudice, although an increasing number broadly enjoin patients to behave in a respectful manner under policies delineating patient rights and responsibilities and indicate that misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto's University Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of patients and health care personnel.

UHN's *Caregiver Preference Guidelines* focus on three key questions: whether the preference for an alternative clinician appears to discriminate against the health care professional on the basis of race, ancestry or other characteristic as provided in the *Ontario Human Rights Code*; whether the request is clinically feasible and/or indicated to a reasonable degree; and whether the clinician wishes to excuse themselves from caring for the patient [27]. Mayo's recently adopted policy directs staff to step in when they observe behavior that is not in keeping with Mayo Clinic values; address the behavior with the patient, focusing the conversation on Mayo's published values; explain the institution's expectations and set boundaries with the individual; and report the incident to supervisors and document it via a patient misconduct form [27].

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; that the title of Opinion 1.2.2, be amended to read "Disruptive Behavior and Discrimination by Patients"; that the body of Opinion 1.2.2 be amended by addition and deletion as follows; and the remainder of this report be filed:

The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.

Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either ~~physicians~~ patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

- (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.
- (b) Always treat patients with compassion and respect.
- (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.
- (d) Prioritize the goals of care when deciding whether to decline or accommodate a patient's prejudiced request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.
- (e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.
- (f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

- (g) Terminate the patient-physician relationship ~~who uses derogatory language or acts in a prejudiced manner~~ only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

- (h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.
- (i) Educate staff, patients, and the community about the institution's expectations for behavior.
- (j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.
- (k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.
- (l) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

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2. AMENDMENT TO OPINION 8.7, “ROUTINE UNIVERSAL IMMUNIZATION OF PHYSICIANS”

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Opinion 8.7

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 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.

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