

ETHICS ROUNDS

Taking Risks to Protect Patients

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In December 2002 the CDC recommended that all health care providers and first-responders—roughly 450,000 people—be vaccinated against smallpox. By the end of March 2003 the number of people vaccinated within this group nationwide was less than 1%. In VA that number was slightly higher, reaching 7% of health care providers by the end of May 2003.

There are several reasons why so many people declined to be vaccinated, but the one that looms largest is the negative health risks associated with the vaccine. The vaccine commonly causes toxic and/or hypersensitivity rashes, can lead to secondary bacterial, fungal, and parasitic infections and/or permanent disability, and the surface virus can easily spread to close contacts. Indeed, the smallpox vaccine is so dangerous, and the contraindications so extensive, that few people even qualify to receive it—another reason the number of vaccinated individuals is so low. For example, in one hospital, of 550 volunteers for the vaccine only 38 qualified to receive it.

If smallpox is at one end of the vaccine spectrum, what about the other end? Consider the following scenario:

Dr. M is a cardiologist specializing in the care of geriatric patients. She is well regarded as a skilled and compassionate physician by both colleagues and patients.

The hospital where Dr. M works recently offered the influenza vaccine to all health care providers, but she declined to be vaccinated. It is now flu season, and several of the patients Dr. M recently treated are suffering from the illness.

Mr R, a frail and immunosuppressed elderly gentleman in his 80's is typical of Dr. M's patients. Given the vulnerability of her patient population, is Dr. M ethically obligated to be vaccinated against the flu (even though vaccination is not required by policy)?

To analyze this case, we first have to back up a little bit and ask why some vaccines are recommended for health care providers. There are really two reasons: to protect health care providers from being infected by patients (thereby assuring that providers remain healthy and available to treat more patients), and to protect patients from being infected by health care providers. These, in turn, are based on two ethical duties practitioners have to patients—to provide care regardless of personal risk, and to minimize harm, in this case by protecting them

from infectious agents during the course of treatment. The recommendation from the CDC that health care providers and first-responders be vaccinated against smallpox was motivated by the first ethical duty—to protect health care providers from the disease so they can provide care to infected individuals without becoming infected themselves, and thereby be able to care for as many individuals as possible.

The flu vaccine is a different story. Influenza does not constitute a serious health risk to practitioners, even though there is some risk of contracting the flu in the course of treating patients, because practitioners are, for the most part, young and healthy. But an infected practitioner can pose a serious health risk to his or her patients. Patients, especially hospitalized patients, who are already ill and vulnerable, are at a significant risk of complications and death from the illness. The CDC estimates that the flu is responsible for roughly 20,000 deaths each year in the United States, and patients over 65 with chronic illnesses are the hardest hit group. In the health care setting, protecting patients from infection by health care workers, and so minimizing the harm patients suffer, is an important rationale for vaccinating staff against influenza and protecting patients.

While the arguments for vaccinating health care providers are based on well-established ethical principles, there are valid reasons for practitioners to decline. For some vaccines, like smallpox, the risks are so high compared to the possible benefits that the vaccine cannot be ethically required. But this is not the case with the flu vaccine. By far the most common side-effect of the flu vaccine is redness and swelling at the injection site, and since it is injected intramuscularly, it poses no risk to close contacts. It also has an efficacy of 70-90% in preventing the flu. Flu vaccine does carry some risk of severe complications, but those are extremely rare—for example, anaphylactic hypersensitivity reactions are known to occur in some individuals with allergies to eggs or other components of the vaccine. For these individuals, prophylactic treatment with antiviral agents is an option for preventing influenza.

Even though the safety and efficacy of the flu vaccine is well established, the best available estimate (employee data are confidential, and vaccination rates are not formally compiled) is that only some 55–60% of VA practitioners receive it. This estimate of VA participation might be artificially low, since some practitioners are vaccinated by other employers, by outside primary care providers, or as veterans, not as employees. But this still leaves a significant number of practitioners who simply decline the flu vaccine. According to a study in the *Journal of Nursing Care Quality*, practitioners' most common reason for declining to be vaccinated is that they do not think it really works, because in a year they received the vaccine they still got the flu (Ludwig-Beymer, 2002). This anecdotal evidence is not a very persuasive reason to forgo the vaccine, since the clinical data convincingly demonstrates the vaccine's efficacy. It is precisely because the flu vaccine is so effective, the risks low, and the potential benefit for patients (not to mention colleagues) fairly high that practitioners have such a

compelling ethical responsibility to be vaccinated, even though it does not rise to the level of an ethical duty.

A patient is not at risk for contracting the flu from a practitioner simply because the practitioner has not been vaccinated, of course—the patient could only contract it if the practitioner actually had the flu. And in that case, the practitioner would have an ethical duty to minimize his or her contact with patients, and take appropriate measures to reduce the risk of transmission until the disease had run its course. On much the same reasoning, in a case like vaccination for influenza a practitioner would not be ethically required to disclose his or her vaccination status to a patient because that information is neither clinically nor ethically relevant, and should have no bearing on how treatment decisions are made. In the case above, Dr. M's exposure to the flu does not endanger the life or well-being of Mr. R if she followed universal safety precautions, and disclosing her vaccine status might hinder more than help any discussion about treatment options, if only by distracting Mr. R from more important considerations about his care.

Health care providers cannot, ethically, be required to accept the risks of vaccination. At the same time, however, there is justification for facility leaders to aggressively promote flu vaccinations as an ethically commendable option for practitioners in the interests of protecting patients. And as a recent study demonstrated, the percentage of practitioners who received the flu vaccine in a facility is generally correlated with the promotional effort made by the facility leadership (Ludwig-Beymer, 2002).