

Mandatory Influenza Vaccinations for Medical Workers: the Degradation of Ethics

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The Story of a Nurse

The following story is hypothetical. Any resemblance to real persons or events is purely coincidental.

Rebecca was a registered nurse who had worked at a major medical system for several years. Every year, Rebecca's annual review was positive. She was a hardworking, team-oriented employee who was loyal to her unit and eager to improve her practice.

At the beginning of the fall season, Rebecca was overjoyed to discover that she was pregnant. A few weeks after learning this news, the hospital where Rebecca worked announced that it was time for all employees to obtain their annual influenza vaccination. Those who did not comply with vaccination were allowed the option to either wear a medical mask throughout the 5-month influenza season, or to be subjected to a permanent dismissal from their position. Every year before this, Rebecca accepted the influenza vaccination without a second thought. This year, she wished to refuse, because of the limited evidence of the safety of the vaccine during pregnancy.

Every year this hospital system offered a bonus to all employees based on the success of meeting organizational safety and performance goals. This year, the hospital determined that a portion of the bonus would be withheld if the organization did not meet the goal of an influenza vaccination rate of at least 90 percent. Employees quickly blamed those who were wearing a mask for the threat to decrease their annual bonus. Rebecca, now masked per policy, soon started to feel the brunt of her decision. "I need that money, Rebecca. If I lose it, you owe it to me," snapped one disgruntled co-worker. Others chose to mock Rebecca's choice of influenza prevention and coughed loudly in her direction. As the final compliance date for the influenza vaccination drew near, co-workers were increasingly polarized and either started inflammatory debates about Rebecca's choice during work hours, or simply ignored Rebecca completely.

As a medical professional, Rebecca was well aware of the medical risks and benefits of the influenza vaccination. However, all medical reasoning slowly became irrelevant. She started to question whether she should comply with the vaccination in order to calm the rage of her co-workers, obtain the yearly bonus, and once again be able to practice without the barrier or humiliation of a bright yellow mask smothering her face. Social integration, monetary gain, and visual targeting started to become the main motivators of Rebecca's decision, rather than her own medical convictions about her own health and that of her growing child.

Ethical Standards

Stories like Rebecca's are not uncommon today. More hospital systems are mandating influenza vaccinations. This

policy raises many ethical concerns.

Current standards integrated into the education of current-day nurses and physicians include discussions over the importance of upholding the four most commonly accepted medical ethics of autonomy, justice, beneficence, and non-maleficence.¹ Although we are to uphold all four standards whenever possible, most medical decisions are complicated. Contradictions in the requirements of these principles call for setting priorities.

In the discussion of mandatory influenza vaccination for medical employees, the most commonly cited ethic is that of non-maleficence to vulnerable patients. The underlying presumption is that the worker poses a substantial risk of transmitting a potentially deadly influenza virus to the hospitalized patient through typical care-giving activities. Arguably, the closer the person's contact is with the patient, the more likely that vaccination of the person is ethically justified.² However, the issue warrants full exploration of each of the four principles.

Autonomy

Beauchamp and Childress¹ define an autonomous action as one made by "normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action." Many of those arguing against mandatory influenza vaccinations have invoked the Nuremberg Code, Title VII of the Civil Rights Act of 1964, and other important documents. The very ethical protections that we are expected to uphold for our patients are not being afforded to us.

Taber's Cyclopedic Medical Dictionary defines the patient in two ways. The first is "one who is sick with, or being treated for, an illness or injury"; and the second is "an individual receiving medical care."³ By our own definitions, in the act of receiving the influenza vaccination, we are the patient. Even though our own body is being affected, the treatment we are receiving is mandated for the benefit of some other patient. In this case, the concerns of autonomy belong to us and our own right to our own treatment without coercion into making a decision for any reason besides our own health.

More than 50 percent of medical professionals would reportedly forgo the influenza vaccination if not otherwise incentivized by their employers.⁴ It would make sense that professionals most acutely aware of medical decisions and the sequelae of forgoing preventive medicine would be afforded the most autonomy over their own medical decisions. However, this is not the case. More than half of those who are most highly educated in medicine do not agree with this decision with which they are forced to comply.

If the people most educated in medicine do not demand their own medical autonomy, how much do they truly value autonomy of the patients they treat? Is the concept of respect for medical autonomy a farce?

Justice

There are many potential breaches of justice in vaccine mandates. First is the potential conflict of interest involving hospitals and their yearly prescribed goals for influenza vaccinations. In 2013, an American Hospital Association bulletin announced that hospitals not complying with a certain vaccination rate for their employees would have a 2.0 percent loss in a specific Medicare payment.⁵ In 2013, this implied that a 100-bed hospital that did not comply with the prescribed vaccination rate would lose approximately \$320,000 in payments.⁶

According to Healthy People 2020, a government initiative poised to make incremental decreases in communicable diseases and preventable health problems, the compliance level of medical employees with influenza vaccination should be 90 percent by 2020.⁷ In a world where fewer than half of medical employees are willing to obtain a flu vaccination without coercion, a mandate for it may be the only way that the hospital could keep this incentive money.

Additional monetary motivators exist for mandatory vaccinations. The World Health Organization (WHO) expects the influenza vaccination industry in the U.S. alone to grow from \$1.6 billion in 2011 to \$2.2 billion in 2018, with a worldwide market totaling a projected \$100 billion in 2018.⁸ WHO attributes the increase in vaccination use to a combination of factors, including increased awareness of communicable disease, increased government funding, and increased profits to the company through higher-priced vaccinations. WHO also repeatedly endorses the vaccination industry as a monetary investment. Influenza vaccinations bring a generous profit to those companies that sell them; there is often a 100 percent price markup.

Medicare incentives, profits to manufacturers, and known conflicts of interest with authorities who are pushing for a vaccination mandate suggest that questionable motives are involved in vaccine mandates.

One further issue of justice is breach of patient confidentiality. Masks or stickers on identification badges advertise the employee's medical decisions to the public.⁹ An employee posting any piece of patient identification in a public space will face some kind of progressive punishment or termination. Why, then, is it acceptable for employers to demand that employees' information be flagged?

Medical masks are not only often ineffective, but could also increase the transmission rate of the influenza virus.⁴ Thus, they may serve no useful purpose while violating principles of justice and autonomy. They may be primarily a tool of coercion; an employee who must constantly wear a mask might decide to submit to a vaccination that they do not want, just to avoid the humiliation, nuisance, or the barrier of constantly wearing a medical mask during work hours.

Beneficence

According to Beauchamp and Childress,¹ beneficence is "an action done to benefit others." On its website, the Centers for Disease Control and Prevention (CDC) highlights a multitude of harms from the influenza virus, with claims that "millions of people are sickened, hundreds of thousands are hospitalized, and thousands or tens of thousands of people die from flu every year" in the U.S.¹⁰ CDC also regularly claims that influenza is

sandwiched between diabetes and kidney disease as the eighth leading cause of death in the U.S., estimated to cause 36,000 deaths every year. With these foreboding numbers, it would be reasonable to assume that any attempts to evade such a rampant and deadly disease would be of benefit to the patient.

However, it is important to understand how CDC defines a case of influenza. CDC separates influenza into two categories: laboratory-confirmed influenza cases, and "influenza-like illness" (ILI). ILI is defined by symptoms: fever (temperature of 100 °F or greater) and a cough and/or sore throat without other known cause of symptoms.¹¹ CDC uses ILI to help track influenza, and uses it occasionally in place of laboratory-confirmed influenza when determining numbers such as mortality and prevalence of flu each season. It is often difficult to determine on the CDC website which illness is referred to: confirmed influenza or ILI. Only one in 1,000–4,000 presumed influenza illnesses are positive through a laboratory-confirmed test.¹² Thus many common illnesses, including streptococcal sore throat, respiratory syncytial virus, and the common cold, could be lumped into statistics on the prevalence of influenza.

CDC statistics for influenza listing it as the eighth leading cause of death are also somewhat unclear. When this statistic is stated on the CDC website, it is a combination of influenza deaths and pneumonia deaths. Yet, only approximately 8.5 percent of pneumonia cases are estimated to be related to the influenza virus.¹³ Adjusting for non-influenza-related pneumonia, influenza is nowhere near the top of the list of fatal diseases. According to the National Vital Statistics, approximately 500 influenza deaths are recorded yearly, a smaller number than deaths from hernia, ulcer, or pregnancy.¹⁴ The CDC's statistics inflate the level of urgency of preventing the usual type of influenza.

Even if the virus were as deadly as CDC officials reported, how much good are we doing for our patients by insisting on an annual vaccination for medical employees? CDC documents report a 59 percent effectiveness of the 2015-2016 influenza vaccine, with parameters of both laboratory-confirmed influenza and ILI as a guide.¹⁵ "This means that getting a flu vaccine this season reduced the risk of having to go to the doctor because of flu by nearly 60 percent," according to Joseph Bresee M.D., chief of CDC's Epidemiology and Prevention Branch.¹⁵

However, current evidence conflicts with these percentages. The Cochrane Collaboration, an organization that completes systematic reviews, merged information from 116 studies to find that 71 influenza vaccinations would have to be administered in order to prevent one case of influenza.¹⁶ It notes that more than 20 percent of the studies have a high risk of bias, which could tilt the results to a falsely elevated efficacy level. This review shows that vaccination status only has an approximately 1.3 percent difference in a patient's chances of acquiring this infection.

What are we accomplishing with a mandatory influenza vaccination? Evidence of inflated mortality estimates and of very low vaccination efficacy erodes the credibility of the rationale for the vaccine mandate.

Non-maleficence

"One ought not to inflict evil or harm" is the underlying concept of non-maleficence according to Beauchamp and Childress.¹ This is the most powerful argument for mandatory influenza vaccinations for medical employees: the duty to not

harm our patient implies the duty not to infect patients with a virus we may be carrying. The argument is that the more medical employees vaccinate themselves for patient protection, the less likely they are to become infected with the influenza virus, and the less likely they are to transmit the virus to patients.

The Cochrane Collaboration completed a review exploring whether vaccination status of the caregiver has any effect on the influenza infection levels of patients for whom they have cared.¹⁷ Despite a high risk of bias in favor of influenza vaccinations, very little-to-no evidence could be found that supported a decreased level in laboratory-confirmed influenza in an institution with a vaccinated staff. Vaccinating employees for patient protection from influenza is simply not evidence-based, and currently there is “no evidence to mandate compulsory vaccination of medical workers.”¹⁷

In addition, non-maleficence concerns more than just patients for whom workers are caring. As discussed above, the workers themselves are also patients, and it is they who must deal with the immediate consequences of the vaccination’s effect on their bodies. There are no risk-free medical interventions, and as the most commonly compensated vaccination in the National Vaccine Injury Compensation program, the influenza vaccination is not free of harmful effects.⁴ Approximately 65 percent of patients who receive the influenza vaccination experience some form of adverse effect, and though the majority of these adverse effects are mild and typically short-lived, the risk of a major health problem is also not implausible.¹⁸ An estimated one or two cases of Guillain-Barré syndrome (GBS) occur with every one million influenza vaccinations, which means this year up to 358 vaccinated patients will develop GBS presumed to be related to the influenza vaccine.¹⁹ Furthermore, 104 deaths as a result of the influenza vaccination have been recorded since 1988,²⁰ a relatively small number that yet serves as a somber reminder of the life-threatening potential of something commonly touted as a harmless medical intervention.

Two factors must be weighed in evaluating for non-maleficence: vaccinating medical workers is not proven to protect the patient from harm, and is not a guaranteed-safe intervention for the worker. Those who mandate these vaccinations are insisting that medical professionals make the exchange of risking their own health in an intervention that is unproven to be of benefit to their patients. This logic is absurd.

Conclusion

A thorough review of all four ethical principles and current evidence suggests potential misinformation and corruption in a multimillion-dollar vaccination industry. As medical professionals, we have a duty to uphold the concepts of medical ethics and to insist on best practices for our patients. However, we seem to relinquish the same standards for our own care that we readily offer our patients. We need to insist on ethical treatment for all patients, including ourselves and our coworkers. A re-evaluation of current practices for vaccination mandates is warranted.

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