

Required Influenza Vaccination for Health Care Workers: The Legal Precedent

In the United States, state and local governments have traditionally been responsible for the promotion and protection of public health. The first immunization law was passed in 1809, when Massachusetts required smallpox vaccinations.

The constitutionality of such laws has been challenged by those who find them coercive. Yet since 1905 the U.S. Supreme Court has held that, in the interest of public health, states can compel vaccination. In 1902 smallpox was epidemic in Boston and other cities in Massachusetts, and local courts ordered vaccination. A Cambridge minister, Henning Jacobson, refused to comply, claiming the law was unconstitutional because it violated the 14th Amendment, which asserts that no state may enact laws that "abridge the privileges" of U.S. citizens. The case eventually reached the Supreme Court (*Jacobson v. the Commonwealth of Massachusetts*, 197 U.S. 11, 1905), which upheld the Massachusetts law, ruling that "the police power of a state must be held to embrace" laws that "will protect the public health and the public safety."

If their patients get the flu, nurses who decline vaccination could be held responsible by a court or a state board of nursing.

Similar laws have been passed in other states. For example, all states have childhood immunization laws requiring proof of vaccination for school entry, with compliance tied to funding. Required vaccines vary by state but typically include those against diphtheria, tetanus, and pertussis; hepatitis B; measles, mumps, and rubella; and polio. Most states permit medical exemptions, and many permit religious or philosophical exemptions as well. While the Supreme Court has never ruled on the constitutionality of religious exemptions, it has held that public health concerns outweigh religious beliefs (*Employment Division, Department of Human Resources of Oregon, et al. v. Smith et al.*, 494 U.S. 872, 1990).

In 2001, after anthrax was dispersed through the mail in New York and other cities, the Centers for Disease Control and Prevention asked the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, in collaboration with other national organizations, to draft the Model State Emergency Health Powers Act (MSEHPA). The act grants additional powers, including the power to compel vaccination, to

state and local health authorities during declared public health emergencies. It also permits authorities to quarantine people who opt for exemption. Writing in the August 7, 2002, issue of *JAMA*, the authors of the act argued that public safety trumps individual rights when there is an extreme threat and citing the 1905 case as one of many legal precedents. They acknowledged that augmenting governmental powers during a state of emergency could pose "serious threats to individual freedoms," but stated that the MSEHPA safeguards those freedoms through checks and balances. (For example, orders for quarantine are subject to judicial review.) As of July 2006, 66 bills or resolutions containing provisions from or related to the MSEHPA had been passed in 38 states and the District of Columbia.

When it comes to private employers mandating flu vaccination for their health care workers, the law is undecided. In 2004, after prolonged education campaigns, only 55% of health care workers at Virginia Mason Medical Center in Seattle were so immunized. The facility decided to make vaccination mandatory—reportedly the first time any private employer in the United States did so. (Informed declination was permitted on medical or religious grounds, but workers who declined had to wear a mask during flu season.) The Washington State Nurses Association (WSNA) filed a grievance, stating that the hospital had violated the union contract and individual nurses' rights by failing to negotiate the issue. The arbitrator agreed and directed the hospital not to implement the policy; the hospital then sued the WSNA. When the District Court upheld the arbitrator's decision, the hospital appealed to the 9th Circuit Court; the case is pending. The court's decision might address only whether a contractual violation occurred, not whether an employer may mandate vaccination. (For more on this case, see *Ethical Issues*, October 2006.)

Most state nurse practice acts assert that nurses have a responsibility to protect the public health; and many states consider failure to follow infection control practices to be professional misconduct. While reporting such misconduct to the state board of nursing is at the employer's discretion in some states, it's mandatory in others. Although most employers still favor a voluntary vaccination policy, nurses should know that a court or a state board of nursing can decide that such a policy doesn't adequately protect the public; those who decline vaccination could be held responsible if their patients got the flu.—*Edie A. Brous, MPH, MS, JD, RN, nurse and attorney in solo private practice in New York City (<http://ediebrous.com>) and the coordinator of Legal Clinic. Contact author: ebrousrnj@nysbar.com.*

Required Influenza Vaccination for Health Care Workers: The Ethical Issues

Vaccinating health care workers against influenza benefits everyone: the workers, their employers, and their patients. As Tucker and colleagues describe, a preponderance of evidence shows that the flu vaccine is effective and safe—and that when more health care workers are immunized, fewer patient deaths occur.²⁴ It seems clear that nurses have a moral obligation to be vaccinated. So can a nurse's decision to decline vaccination be ethical? And is it ethical for a hospital or the state to compel vaccination?

Can a nurse's decision to decline vaccination be ethical?

In ordinary, nonemergent health care encounters, a patient's decision to receive or decline vaccination is honored. While the clinician knows that vaccination will benefit the patient, once the patient has been well informed, the clinician's obligation has been met. Most of the time, a patient's declination is unlikely to affect large numbers of people who are vulnerable to infection. When the risk is higher—as when the patient or someone the patient lives with is immunocompromised or elderly—greater attempts at persuasion are warranted; still, the decision remains the patient's.

But a nurse facing the decision to receive or decline vaccination is not a patient. The nurse's decision, as well as overall health status, can affect the well-being of all those in her or his care, many already vulnerable to infection. In accepting a nursing license, one accepts a degree of obligation to protect the public's health. And in recognizing that license, society has some stake in enforcing that obligation.

Nurses who forgo vaccination do so for many reasons. Clearly, declination for medical reasons (such as an allergy to egg proteins, which the vaccine contains) is ethically valid,

while declination for reasons of convenience is not. The most troubling reason for declining vaccination is the belief that the vaccine can cause influenza or is otherwise unsafe. Neither the intramuscular nor the intranasal forms of the vaccine can cause influenza, and adverse effects are rare. The American Nurses Association's 2006 position paper, *Risk and Responsibility in Providing Nursing Care*, offers guidance as to what level of risk is acceptable. It states that a nurse has a moral obligation to act when a patient is otherwise at "significant risk of harm," when the nurse's intervention will probably prevent harm, and when "[t]he benefit the patient will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse."

A few nurses continue to disagree with the scientific consensus that the vaccine is safe. The right of individuals to make autonomous decisions has sometimes been invoked to support declination in such cases: it's reasoned that just as we respect a competent patient's choice, so must we respect the nurse's. But as I wrote in a previous column (*Ethical Issues*, October 2006), there's a difference between decisions based on evidence and those made on misinterpreted or illegitimate data.

It's distressing that, as Tucker and colleagues indicate, under current voluntary vaccination policies the vaccination rate among nurses and other health care workers has remained very low, even after repeated education and awareness campaigns. Given the extremely low risk associated with flu vaccination, abundant evidence that a vaccinated health care workforce prevents patient deaths, and nurses' obligation to keep their patients safe, compulsory vaccination may indeed be justified. It's true that forced treatment must be understood as a constriction of individual freedom and instituted with sufficient gravity and caution. Requiring an informed statement of declination is one safeguard. But in my view, the real question remains: why aren't more nurses voluntarily doing the right thing?
—Douglas P. Olsen, PhD, RN, associate professor, Yale University School of Nursing, New Haven, CT, and a coordinator of Ethical Issues.
Contact author: douglas.olsen@yale.edu.