



ACOEM Consensus Opinion Statement

This is a position statement approved by the ACOEM Board of Directors on July 30, 2005.

Influenza Control Programs for Healthcare Workers

Influenza continues to be a major cause of death and disease, readily spread by respiratory droplets both in the community and in the hospital environment. Not only are health care workers at risk of infection from exposure to their patients, but patients are potentially at risk of contracting the disease when exposed to infected employees.

The most tangible and measurable strategy to control transmission of influenza between patients and staff is vaccination on an annual basis just prior to the influenza season. Clearly, immunization of the general population with emphasis on high-risk groups is an appropriate public health strategy, not only to benefit individuals who are vaccinated but also for the added benefit of “herd immunity.” In the context of the work environment of health care, vaccination of employees may not only protect employees from their infected patients but may also minimize the risk of transmission of influenza by employees to otherwise debilitated patients.

While there are likely economic benefits of employee vaccination (lower utilization of employee medical benefits and stable staffing during the busy flu season), such consideration falls outside the scope of this position statement and could be construed as an ulterior motive for an otherwise bona fide benefit for employees. The health benefits of vaccination should stand on their own merits.

Health care workers practice in a variety of settings, and it makes sense particularly to encourage vaccination of those employees who work with the most vulnerable patients. In acute care hospitals, nosocomial influenza outbreaks have impacted primarily neonatal intensive care, myelosuppressed, and geriatric units.¹⁻⁵ The greatest risk of staff-to-patient transmission occurs in long-term care facilities, due to the close and prolonged contact between residents and their caregivers.⁶

National vaccination rates for health care workers have hovered around 40 per- cent, even during years when there has been an ample supply of vaccine.⁷ On the other hand, comprehensive plans to increase compliance have been successful – as demonstrated in California and Minnesota – through incentives, mass vaccination clinics, peer vaccination programs, and creative marketing, with a rise in compliance at one facility from 42 to 76 percent over the span of two years.⁷

Therefore, ample reasons exist for employers to sponsor influenza vaccination programs for their employees and to vigorously pursue strategies to maximize participation. However, the American College of Occupational and Environmental Medicine (ACOEM) believes that mandatory influenza vaccination for health care workers is not justified for several reasons – the vaccine itself is variably effective; vaccination does not preclude the need for other controls; and a coercive program has the potential to harm the employer-employee relationship.

Despite the primacy of vaccination in an influenza control program, it remains only one prong in a multi-faceted approach to infection control. Employees must also adhere to appropriate use of handwashing and personal protective equipment, and they should exercise proper respiratory etiquette in the work- place and self-removal from work when experiencing symptoms of a communicable respiratory illness. Influenza vaccine itself has variable effective- ness, as low as 47 percent overall during the 2002-2003 season due to antigenic drift of the A virus, and typically no more than 70 to 90 percent effectiveness during a year with a good match between antigens in the vaccine and circulating virus.⁸ There are also medications, such as rimantadine or oseltamivir, which have efficacy comparable to vaccination when taken as prophylaxis and can shorten the duration of illness and transmissibility when taken within 48 hours of symptom onset.

Given the ubiquitous nature of influenza in the community, patients will continue to be exposed to influenza through family members and friends regardless of the vaccination status of their health care workers, with whom

they have much less intimate contact. Thus, reliance on employee vaccination alone for prevention and control of influenza in the health care environment offers a false sense of security and ignores some of the more practical but also effective means of minimizing nosocomial transmission.

If a health care worker chooses not to accept influenza vaccination or prophylactic medication, the employer may need to make some difficult decisions. Obviously, a breach of sanitary precautions should lead to corrective action, but refusal to take prophylactic measures that may affect the worker's personal health, i.e., live intranasal vaccine, injected inactivated vaccine or oral medication, raises ethical issues. Also, an unvaccinated employee does not pose an immediate threat to patients if he/she has no respiratory symptoms. Even with such symptoms, the other measures mentioned above can greatly reduce the risk of transmission.

The rights of the patient must be weighed against the rights of employee. There may be work settings, such as an organ transplant unit, in which the patients are so immunocompromised that any risk of nosocomial transmission warrants administrative action. In such a setting, the unvaccinated employee might be offered temporary reassignment during the influenza season, but such action could not be justified in all health care settings.

ACOEM endorses a multifaceted influenza control program in all health care facilities and strongly encourages health care organizations to facilitate participation by providing influenza vaccine, associated supplies and services, and/or prophylactic medication at no expense to the employee. However, ACOEM discourages generalized policies requiring mandatory compliance with employee vaccination or prophylactic medication. Such policies have already been successfully challenged in Canada.^{9,10} It has been suggested that healthcare organizations should require employees who refuse vaccination to sign declination forms.¹¹ There is no evidence to suggest that such programs will increase compliance, and the burden of requiring compliance from those who have already chosen not to participate would tax employee occupational health resources that could otherwise be devoted to positive reinforcement for compliance. Influenza control can be successful with creative programs that employ the "carrot" rather than the "stick" while still respecting the rights of both patients and employees.

This position statement applies to seasonal influenza and does not necessarily apply during a major antigenic shift in the virus resulting in a pandemic situation.

References

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