Immunization of healthcare providers: A critical step toward patient safety

At the beginning of the 21st century, transmission of vaccine-preventable diseases (VPDs) and large outbreaks continue to challenge healthcare facilities even in developed countries with long-standing vaccination programs. Such outbreaks are often costly, in terms of number of cases involved, patient morbidity and occasional fatalities, infection control, contact tracing, and disruption of healthcare services [1]. Many VPDs are considered as “childhood” diseases, may develop with atypical symptoms in adults, and/or have been rarely encountered by healthcare providers (HCPs) in the vaccine-era, and thus may not be diagnosed early, escaping prompt implementation of infection control measures [1,2]. Susceptible HCPs are at risk for acquisition of disease and are sources of infection for susceptible high-risk patients. The rationale for HCP vaccination relies on the need to protect them and indirectly their vulnerable patients, but also to preserve essential healthcare infrastructure [3].

Hepatitis B and influenza vaccines drive vaccination policies for HCPs globally. Despite the fact that both vaccines are recommended for HCPs for almost three decades, studies indicate suboptimal vaccination rates with voluntary vaccination policies [3,4]. Attempts to increase influenza vaccine uptake by HCPs the past decades have been largely unsatisfactory outside of the United States. The 2009 pandemic issue of HCP vaccination against influenza H1N1 accelerated the adoption of mandatory vaccination policies for HCPs in the United States with resulting excellent coverage rates. The principles of patient safety, HCPs autonomy and HCPs professional and ethical responsibility, and legal issues about mandates frame the arguments for and against mandatory vaccinations [3,5,6]. Although the issue of mandatory vaccination against influenza drives the issue of HCP vaccinations nowadays, a holistic rather than a disease-specific approach for HCP vaccinations is needed. Vaccination policies for HCPs differ across Europe in terms of recommended vaccines, indications and legislative frames. Even now and despite large measles epidemics in Europe over the past decade, there are no HCP vaccination policies against measles in place in several European countries [7]. Studies among HCPs in Europe and elsewhere indicate significant immunity gaps against several VPDs. There is a critical need for stronger vaccination recommendations for HCPs taking into account the current local and international epidemiological trends, and a compelling case for mandatory vaccination policies against infectious diseases which can be transmitted to patients and for which safe and effective vaccines exist. Patients expect that HCPs will not place them at risk by the transmission of diseases that are vaccine-preventable.

This issue is dedicated to VPDs and vaccinations of HCPs. Our aim was to cover a significant spectrum of topics, with emphasis on VPDs re-emerging in developed countries (e.g. measles in Europe and the United States, pertussis in the United States), as well as hot public health topics (e.g. the mandatory vaccination policies, the growing anti-vaccination movement). Issues of communication and education of HCPs including healthcare students, the role of HCPs as models for the general public, and practical issues of delivery of vaccinations, are also discussed. Internationally recognized health professionals participated in this endeavor. We thank them. We present this work with the hope of triggering fruitful discussions and encouraging efforts to promote safety both for HCPs and the patients they are privileged to care for.

References


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