Doctor questions requiring flu shots for health care workers

In the previous issue, Dr. Lori Keough, PhD, argues that it is unethical for Health Care Workers to fail to get immunization against seasonal influenza or to wear a mask during flu season (whenever that is). She says that we HCWs have an obligation not to expose our patients to vaccine preventable diseases, citing the 19th-Century failure of physicians to recognize that they were the sources of infection (for puerperal fever – not a vaccine preventable disease).

I am up to date on all of my vaccines – with the exception of influenza virus. I wash my hands and, I hope, follow practices of "non-maleficence" and "beneficence" of doing no harm. However, I remain unconvinced that requiring HCWs to be vaccinated or to wear masks is anything other than overreaching on the part of the health department and other regulatory agencies.

I have no problem with *recommendations* that HCWs be vaccinated, provided that they are not allergic to the vaccine. I have no problem with HCWs receiving sick pay when they get a flu-like syndrome from the vaccination. I have no problem with HCWs being vaccinated with vaccines that are effective.

How effective is the current vaccine against influenza? Not very effective according to many studies. Is 56% effective[1] adequate? This is the estimated rate of effectiveness for persons over 65. I happen to be over 65; I expect a better "bang for my buck" if I am to submit to influenza vaccination.

What are the data that show that wearing masks significantly lowers the rate of transmission for influenza between HCWs and patients? Not too good, it turns out. There do not seem to be many published studies showing efficacy.[2] Hand washing is probably the better protector.

Though not a politically conservative person, I confess to having a problem with regulations that ask us to do things that don't work so well. I do not share Dr. Keough's enthusiasm that "…the obligation to protect patients from seasonal influenza has been enshrined in Rhode Island law…" Let us enshrine things that work, not things that don't work very well. Vaccines and masks are costly.

Steven G. McCloy, MD
Providence, RI

1. www.medscape.com/viewarticle/779816
2. www.medscape.com/viewarticle/766508

Impact of nursing-centered HIV testing using standing orders in RI

The CDC now recommends that all Americans between the ages of 13 and 64 years old be tested at least once for HIV and those at higher risk be tested more frequently, such as yearly. This is a daunting task. Why not put HIV testing in the hands of nurses?

Interventions that have been effective in the hospital setting, such as influenza and pneumococcal vaccination have been accomplished through empowering nursing. Nurses spend more time with patients than physicians. Opening up a conversation related to HIV can provide a nurse with the opportunity to inform the patient of risk factors and counseling on prevention of HIV.

In an effort to offer HIV testing to inpatients at The Miriam Hospital, a pilot project was initiated utilizing Standing Orders for Routine HIV (SORT) testing by nurses.[1] During the admission process, nurses provided patients with a tailored brochure describing the CDC recommendations that conformed to those of the RI Department of Health. The patients were informed that HIV testing would be included in their routine admission blood work, unless they declined. In patients who did not decline, the nurses activated a standing order. ELISA was used as the screening test. Negative results were provided to the patients by the nurses and the positive results by the attending physician (with a commitment from Infectious Diseases to provide those results). This was done after appropriate training of the nursing staff and full review through the Lifespan Institutional Review Board, Patient Care Committee, and Medical Executive Committee.

SORT was well received by patients, nurses, and physicians; 342 eligible patients were screened over a period of 15 months. All HIV test results were negative. Recent studies demonstrate that voluntary HIV screening is cost effective even in health care settings in which HIV prevalence is low.[3-5] The project did not require any additional staff to be hired. This type of approach has the potential to greatly influence HIV testing around the country. Other models of testing have required hiring of specified staff or adding this task to physician duties, which did not yield the desired increase in testing.

In RI in 2011, patients aged 18-64 comprised of 48% (63,211 of 130,652) of the total hospital discharges.[2] Assuming that 50% of inpatients are offered HIV testing through SORT, roughly 31,605 patients will be offered HIV testing in RI annually.

We propose that this nursing-centered model of HIV testing could easily be rolled out around the country.

1. Costello JF, Sliney A, Macleod C, et al. Implementation of Routine HIV Testing in an Acute Care Hospital in Rhode Island: A Nurse-Initiated Opt-Out Pilot Project. *J Assoc Nurses AIDS Care.* 2013 Sep-Oct;24(5):460-8.
2. HCUP net. Information on stays in hospitals for participating states from the HCUP State Inpatient Databases.
3. Walensky RP, Weinstein MC, Kimmel AD, et al. Routine human immunodeficiency virus testing: an economic evaluation of current guidelines. *Am J Med.* 2005;118:292-300.
4. Paltiel AD, Weinstein MC, Kimmel AD, et al. Expanded screening for HIV in the United States – an analysis of cost-effectiveness. *N Engl J Med*. 2005;352:586-95.
5. Sanders GD, Bayoumi AM, Sundaram V, et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *N Engl J Med.* 2005;352:570-85.

Authors
Neha Alang, MD
Joanne Costello, PhD, MPH, RN
Cindy MacLeod, BSN, ACRN
Michelle Carpentier, MSN, RN, OCN
Patricia Costa, RN, BSN, ACRN
Jennifer A. Thiesen, RNP
Anne Sliney, BSN, ACRN
Timothy Flanigan, MD, FIDSA

Correspondence
Neha Alang, MD
nalang@lifespan.org