effects … ."[1] Compensation for vaccine-related adverse effects is an interesting suggestion, but it is important to note that Health Canada acknowledges that "currently, Quebec is the only jurisdiction in Canada to have a compensation plan [for vaccine-associated adverse events]."[2] Many health care workers in Ontario have been promised by their employers that they will not dispute any compensation claims. This is misleading, for it suggests that compensation is actually available.

Offering vaccination as an option to our health care workers may be supportable, but coercion, whether financial or emotional, truly constitutes a violation of both ethical and legal rights. Perhaps a better solution would be to review infection control procedures, to prevent mass transmission and to reconsider attendance management policies that effectively prevent ill workers from taking necessary time off.

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References
1. Rea E, Upshur R. Semmelweis revisited: the ethics of infection prevention among health care workers [commentary]. *CMAJ* 2001;164(10):1447-8.
2. Immunization in Canada. In: Canadian National Report on Immunization. *MMWR Morb Mortal Wkly Rep* 1996;23S4.

[The authors respond:]

As Catherine Diodati rightly points out, Quebec is currently the only province with a compensation program for severe vaccine-associated adverse effects. In Manitoba, a law commission recently recommended that the province institute a compensation program.[1]

Society has an obligation to balance burdens imposed on individuals for the communal good with public programs and policies to care for those individuals should they suffer an adverse consequence. Although we made this argument with regard to vaccination,[2] we agree with Diodati: the same principle applies equally for health care workers who stay off work to avoid infecting their patients. They should not be made to suffer adverse economic consequences for doing so. Putting this into practice has long been a thorny management issue. It has been particularly topical over the past few influenza seasons in Ontario, where there has been a concerted effort to improve staff vaccination rates in hospitals and nursing homes. Managers may be concerned about potential abuse of policies that pay staff to stay home when ill. Whatever implementation and monitoring procedures are developed to address this concern, the best infection control solution when staff contract influenza despite vaccination seems to be paid sick leave. Another useful option may be to reassign workers who are more mildly ill but may still pose a risk to patients to duties that do not involve patient contact. These approaches are relevant for many other communicable diseases and health care situations (the transplant ward, for example).

However, the obligation to do no harm is not coercion. It is a fundamental ethical principle for those of us who provide health care. We believe that it can and should be extended to nonprofessional staff who provide direct patient care. The obligation to do no harm — given the balance of potential risks and benefits — includes one's own vaccination for influenza. Influenza is a highly contagious airborne disease; rigorous handwashing and good sanitation are not enough.

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References
1. Manitoba Law Reform Commission. *Executive summary of report on compensation of vaccine-damaged children*. Winnipeg: The Commission; 2000. Available: www.gov.mb.ca/justice/mlrc/pubs/vaccine.html (accessed 2001 Nov 22).
2. Rea E, Upshur R. Semmelweis revisited: the ethics of infection prevention among health care workers [commentary]. *CMAJ* 2001;164(10):1447-8.