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COVID-19 Vaccine Mandates for Transplant Patients: Caring for Patients Versus Turning Them Away

Keren Ladin, Andrew M. Flescher, and Peter P. Reese

Following aggressive Delta and Omicron waves of coronavirus disease 2019 (COVID-19), hospitals have been grappling with setting vaccine mandate policies to protect patients amidst polarized public opinion. These issues have recently surfaced as many transplant programs remove unvaccinated patients from the waitlist or refuse to list them, making them ineligible for transplant.[1,2] We conclude that vaccine mandates are ethical. Yet, concern for possibly increasing health inequities should compel transplant centers to employ techniques such as a patient-centered trauma-informed (PCTI) approach when implementing a vaccine requirement. Such techniques may offset mistrust and counter the misinformation that prevents potential recipients from accepting vaccines.

Imposing minimal conditions on transplant eligibility is well established. These conditions balance potential risks and benefits to patients while ensuring that organs are allocated judiciously. For example, most transplant centers require that patients stop smoking and substance use, receive compulsory vaccinations, and complete appropriate cardiac and cancer screening. Appeals to the principle of autonomy in the name of "medical freedom," as grounds for resisting a vaccine mandate, ignore precedent and call into question all evaluation criteria that seek to ensure successful outcomes. Moreover, transplanting unvaccinated patients enables harm by undermining the best medical interests of the candidate who rejects vaccination, unduly raising risk to immunocompromised patients, and endangering clinicians during routine transplant care. Yet, as COVID-19 vaccine mandates become politicized, we also acknowledge the problem that hospitals risk losing control of their narrative, inviting unintended consequences. These unintended consequences include exacerbating disparities among structurally marginalized groups, further fueling concerns about denial of treatment, judgment, and bias within health care.

In Support of Vaccine Mandates in the Transplant Setting

COVID-19 vaccines protect transplant recipients from serious illness and death.[3] Kidney transplantation involves severe depletion of T cells because of induction treatment (typically with anti-thymocyte globulin), followed by lifelong immunosuppression that renders recipients susceptible to infectious complications.[4,5] Unvaccinated kidney transplant recipients have a significantly higher risk of severe COVID-19 because of immunosuppression, comorbidities, and frailty that accompany advanced kidney disease. Among kidney transplant recipients, the mortality rate with COVID-19 was reported to be as high as 25% early in the pandemic and more recent reports estimate a death rate of 16.9%-21% among symptomatic kidney transplant recipients.[6,7] When administered prior to transplant, vaccines offer important protection from severe illness following severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. Moreover, pretransplant patients receiving in-center hemodialysis are likely to experience elevated rates of COVID-19 morbidity and mortality owing to the challenges of a congregate setting.[8] Vaccination is expected to reduce risks of mortality and adverse outcomes in this population.[9]

Such research bolsters numerous ethical arguments supporting vaccine mandates. First, vaccine mandates promote utility, as transplant recipients who are vaccinated are more likely to survive if infected with SARS-CoV-2. Second, the principle of beneficence requires that clinicians act to protect the patient and defend the well-being of others.[10] Mandating vaccines for transplant recipients protects all stakeholders in the hospital and dialysis settings, not the least of which are recipients themselves. Third, mandating a medically necessary vaccine, in keeping with social justice, protects scarce resources and acknowledges that, in the context of a pandemic, individual actions have broad implications for health risks faced by vulnerable patients. These arguments hold true especially for pediatric candidates, who should be protected and who may be unable to obtain vaccination over parental objections.

Critics of vaccine mandates assert that they violate individual liberties and patient autonomy. While autonomy is customarily associated with respect for persons and medical freedom, it also importantly holds that we must "respect individual's independent choices, *as long as the choices do not impose harm on others*."[11] That is, a reasonable constraint on autonomy is that it does not come at the cost of others' well-being, including through the preventable spread of SARS-CoV-2.

Will Mandates Impose More Harm Than Good?

While objections to mandates based on autonomy fall short, hospital leaders must recognize the potential for unintended consequences. Without appropriate messaging, vaccine mandates may contribute to entrenched disparities in access to transplantation, if those with greater levels of vaccine skepticism are delisted at higher rates than other groups. For structurally

marginalized groups who continue to experience discrimination, mistrust may extend to institutions such as transplant centers that issue vaccine mandates, exacerbating disparities in transplantation.

Second, without a uniform approach across transplant centers, well-informed and wealthier patients may simply travel to centers without mandates. This could disrupt care and disproportionately benefit persons with greater resources (eg, time, money, literacy) who could align their vaccine preference with a center ready to treat them. These concerns echo those stemming from multiple listing, which benefits patients able to meet residency and financial requirements at multiple centers.

Moreover, transplantation is uniquely dependent upon public participation. If vaccine mandates inflame negative sentiments toward transplantation, organ donation may decline. This will diminish the transplant system's ability to save lives. Souring public sentiment following a scandal involving transplant hospitals in Germany led to a precipitous decline in organ donation in 2010 that persists, underscoring the long-lasting harms of politicizing transplantation.[12]

What Obligations Do Vaccine Mandates Impose on Transplant Centers to Maintain Equitable Access to Care?

Critics of vaccine mandates may raise equity concerns if they envision that patients refusing vaccines do so owing to misinformation about vaccine safety or distrust. Political affiliation also remains a robust predictor of vaccine status.[13] Lack of trusted messengers has played a key role. Politicized messages of scientists and physicians have contributed to fear and misinformation, as have inconsistent messages from federal health agencies.

We propose a clear, national policy that supports vaccine mandates for transplant candidates and recipients using a PCTI approach, a technique that acknowledges past trauma and its impact on patient interactions and treatment decision-making.[14] PCTI builds upon trusted patient-clinician relationships and assures a level of autonomy and control for patients over their care, and seeks to prevent retraumatization in clinical situations. PCTI is possible even if vaccines are mandated, by allowing patients control over the timing and location of vaccination and type of education (eg, meeting with clinician, peer support, written and multimedia materials). Informing patients in terse letters that they were ineligible to receive kidney offers until vaccinated strays from PCTI care, which acknowledges that vaccination demands can alienate those persons whose suspicions about vaccination are grounded in experiences of oppression, disrespect, and mistrust.[15] PCTI calls for compassion and service delivery that promotes safety, trustworthiness, transparency, peer support, collaboration, empowerment, and dignity by incorporating awareness about trauma into policies and messaging (Fig 1).[16] Although the prospect is perhaps daunting, centers can incorporate PTCI prospectively with all new patients, and should communicate personally with waitlisted patients during their annual visit. If reflective of the US population, less than one-third may express vaccine hesitancy requiring greater outreach.

Sustained investment in effective messaging, transparency, time to process, and workforce development are critical to successfully vaccinating transplant patients. For example, although in the early phases of the pandemic vaccine uptake among persons identifying as Black or Latinx had lagged behind White Americans (largely owing to structural inequalities),[17,18] improved access, time, and outreach by trusted sources have narrowed disparities significantly. Some studies suggest that Black Americans are twice as likely to trust COVID-19 information when care is race-concordant.[19] We acknowledge that race-concordant care is often absent in the transplantation setting, where only 5.5% of transplant surgeons identified as Black in 2013.[20] Transplant centers should better engage with local communities and vaccine outreach efforts to mitigate structural racism and improve trust. The Black Doctors COVID-19 Consortium offers transplant programs a compelling example (https://blackdoctorsconsortium.com/). Transplant centers might also follow successful examples of "promotoras," lay health workers in the Hispanic community, whereby vaccinated transplant patients could be trained and enlisted to talk with hesitant patients. Many transplant patients identifying as people of color are leaders in the transplant community and effective ambassadors for complex public health issues such as living donation. Their experience should be sought after in addressing vaccine misgivings.

At a minimum, patients should have an opportunity to discuss their concerns with a trained and accessible clinician or peer before being faced with consequences. Transplant programs must monitor the distribution of delisting patients across demographic groups and assess their success in promoting vaccination. These data should be publicly reported and used to revise counseling practices.

Finally, we underscore that COVID-19 vaccine mandates—like other requirements for transplant readiness—should adapt to meet the evolving pandemic. Future scientific findings about the spread of SARS-CoV-2 variants, for instance, might lead to reasonable calls to require new boosters as part of mandates. Alternatively, if new treatments for COVID-19 are highly successful for transplant patients, COVID-19 vaccine mandates might be relaxed.

Conclusion

Mitigating the risks of COVID-19 to transplant patients requires vaccination, but it also requires a deep commitment from the transplant community to improve patient-centered care and diversity. Although transplant programs are justified in imposing vaccine mandates,

Figure 1. Checklist for a patient-centered trauma-informed (PCTI) approach to transplant vaccine mandates. Based on information from the Substance Abuse and Mental Health Services Administration.[18]

unintended consequences underscore the collective responsibility that accompanies vaccine mandates.

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