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Ethics Dispatch

"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- Ludwig Wittgenstein

COVID-19, Organ Transplants & Scarce Resource Allocation

The COVID-19 pandemic has put a spotlight on many issues of healthcare. One area that has recently been of focus involves organ transplantation and unvaccinated populations. Though ethical issues surrounding transplantation are not uncommon, COVID-19 has magnified very specific issues, including availability, procurement, and allocation/distribution.

News stories tell of unvaccinated patients being turned away from solid organ transplants (SOT). As controversial as this determination may seem, there are ethical and medical grounds for it. In a recently published paper, Kuczewski et al. (2021) state:

Requiring this vaccination is entirely consistent with the well-developed ethos of transplantation programs that require SOT candidates and their support team to take reasonable steps to increase the chance of a successful outcome in the short and longer-term. Furthermore, the immunosuppression required by the graft means that vaccination posttransplant may not be as effective and requires a longer series of immunizations. It is reasonable that physicians decline to place patients in this position of vulnerability unless they are willing to use the simple and safe remedy at hand to ameliorate the situation, i.e., the vaccines. (Kuczewski et al. 2021)

In other words, the reasons for requiring COVID vaccination of SOT candidates are medically founded. Vaccine confers protection against severe illness from COVID-19, which is particularly important in cases where one is immunosuppressed, as are organ recipients. There also is precedent. These guidelines align with well-established requisites for transplant recipients regarding other routine vaccinations, smoking cessation, and adherence to medical regimens.

COVID vaccine mandates for SOT are also supported via bioethical principles, particularly the balancing of the principle of beneficence and justice. Kuczewski et al. refer also to the principle of stewardship:

The recommendations are based on a combination of enduring ethical principles and their application in the current context. The application of these principles are done in

accord with established standards involving other requirements. The COVID vaccines are highly effective against the current variants prevalent in the pandemic such as the Delta variant. As a result, vaccination is clearly required by the principle of stewardship/utility. The requirement for vaccination of the SOT candidate should probably continue in perpetuity, provided that the available vaccines are highly effective against prevalent variants. (Kuczewski et al., 2021)

Organ transplant teams should be good stewards; they ought to ensure the successful transplantation of organs to the best of their ability. Requiring that patients be vaccinated is a means of ensuring this medical benefit. Given this, medical providers are bound, via ethical principles and established medical protocol, to require COVID vaccination of patients who want to be organ transplant recipients.

Ethicist Bernard Lo's reflections on transplantation protocols offer possible arguments against COVID vaccine mandates in SOT. Lo claims there is likely some bias in transplant protocols aimed at optimal surgical outcomes with both patient survival and improved quality of life. While protocols may strive for objectivity, they inevitably involve complex and subjective value judgments (Lo, p. 305). It may be that there is a measure of unfair bias then in a policy mandating COVID vaccine for SOT.

Lo warns also against moral judgments regarding patient responsibility for conditions leading to organ failure and the need for organ replacement therapies. He considers the example of a patient with a history of alcoholism who nonetheless gets a liver transplant. Some may protest that organs should go to those who develop end-stage liver disease "through no fault of their own." But doing so fails to take into consideration the social determinants of health contributing to many health conditions.

Because alcoholism has genetic and environmental components that are beyond the person's control, it would be unfair to hold a patient responsible for it. Moreover, criteria for disqualification are inconsistent and arbitrary, and treatment for alcohol dependence may not be offered. Furthermore, judgments of moral responsibility are not made for other illnesses. (Lo, p. 307)

If patients were refused organ transplantation on grounds of their substance use disorder history as a personal fault, that would be an ethical error. Transplant evaluation ought to focus on relevant clinical factors, not moral judgments, for optimizing patient outcomes. Psycho-social factors are considered also, but in relation to whether they will impact successful outcomes. A history of substance use disorder is relevant to liver transplant evaluation then not as a moral issue but relative to anticipated recidivism and possible co-morbidities such as cardio-vascular disease or chronic kidney disease. Typically, counseling is mandated along with at least six months sobriety prior to listing. Again, this matters clinically, and ethically also in regard to utilizing well the scarce resource of transplantable organs.

Globally, and for at least some persons in this nation, social determinants play a factor in why they remain unvaccinated. Many still lack access to healthcare resources.

Others, through no fault of their own, lack knowledge with respect to vaccine efficacy and efficiency. Even some who have access to online sources of information are more prone than others of us to be fed mis/disinformation about vaccines, hence stoking fear instead of promoting insight. If such individuals find their way to a transplant program, is it discriminatory then to mandate a vaccination that they have been socially conditioned to fear?

The consensus of transplanters and bioethicists is that COVID vaccine mandates, especially for SOT, are ethically justified despite some relatively weak counterarguments. In the previously cited article recently published in the *Journal of Heart and Lung Transplantation,* co-authors summarize widespread agreement:

We recommend that vaccination for COVID-19 should be a requirement for waitlist activation for solid organ transplant (SOT). We also recommend that such vaccination be required of the primary member of the in-home support team. We argue that these requirements are consistent with current standard practices that draw on a well-established ethical framework. As a result, these recommendations should be easily received and are only controversial owing to the inflamed and politicized state of public discourse. (Kuczewski et al., 2021)

Bioethics in the News

- Hospital Bioethicist Calls Hospital Situation Dire
- Why a Universal COVID-19 Vaccine Mandate is Ethical Today
- No Vax, No Kidney: What are the Bioethics Behind UCHealth's Decision
- Dr. Eric Cassell, Bioethicist Who Put the Patient First, Dies at 93
- Opinion: COVID-19 Vaccine Should Be Mandatory for Healthcare Workers

Happenings at the Center

- Our Director of Membership and Ethics Education Ryan Pferdehirt recently published an article in the Journal of Healthcare Ethics and Administration. The article may be accessed here!

- We have two more Medical Ethics Immersion Workshops scheduled this Fall. Click here to register for the workshop on November 4th, and here to register for the workshop on November 11th.

Case Study

The patient is 50 years old, identifies as female, and suffers from end-stage renal failure (ESRD). She is currently on hemodialysis but not tolerating it well. A referring nephrologist believes that this patient needs a kidney transplant for longer term survival as well as improved quality of life. The transplant program to which the patient is referred urges all patients to be fully vaccinated against COVID-19, even though neither their hospital policy nor the transplant program's candidacy criteria explicitly include mandated COVID vaccination. It is still being discussed, although not much debated. When counseled to get vaccinated as a matter of optimizing transplant outcomes when immuno-suppressed, this patient refuses. She doesn't want "a scary vaccine" and definitely does want to be placed on the transplant list. "I'll take my chances of getting COVID," she says. The renal transplant team is reluctant to proceed. They call for an ethics consult. What should be done?

Ethical Musings: Social Factors and Impartiality

In discussing the ethics of scarce resource allocation, Beauchamp & Childress state:

We defend a system that uses two stages of substantive standards and procedural rules for rationing scarce medical resources: (1) criteria and procedures to determine a qualifying pool of potential recipients . . . and (2) criteria and procedures for final selection . . . . Criteria for screening potential recipients of care fall into three basic categories: constituency, progress of science, and prospect of success. (p. 288).

Interestingly, the first criteria, that of "constituency", is a social factor. This can pose a challenge for ethical process. As Beauchamp and Childress state, "These criteria are entirely nonmedical, and they involve moral judgements that often are not impartial, such as excluding noncitizens or including only veterans. These clientele boundaries are sometimes acceptable, but often have been dubious" (p. 288).

Ethical health care providers want to provide resources as medically appropriate and also fairly. Given this, we might wonder whether incorporating social factors impedes fairness. After all, fairness implies impartiality. To the extent that COVID vaccine hesitancy is grounded in social conditions, and if refusal to be vaccinated results in disqualification for solid organ transplantation (SOT), is this fair? If we take social factors into consideration when determining organ transplant candidacy, it seems we are no longer being impartial or fair. This may be why some unvaccinated persons find SOT vaccination mandates unsettling or even enraging. If enabled to understand the ethical and clinical grounding for those mandates, at least some opponents might be persuaded of their justification.

It is fair to deny scarce resources to a patient by appealing to an argument of utility, rather than an argument of constituency. Writing in the *Journal of the American Geriatrics Society*, Farrell et al. (2020) state:

A just healthcare system should treat similarly situated people equally, as much as possible. There is something particularly unjust about membership in a class, such as

an age group, determining whether a person receives health care. Not only is membership in a class defined by characteristics such as race, sex, or age, beyond the individual's control, but the use of these criteria might conceal implicit biases and other social inequities. Health care may be distinct in terms of requiring equal access because it is critically important to many other goods in life across the life span. These factors suggest that basing resource allocation decisions on advanced age may violate the ethical principle of justice. (Farrell et al., 1144)

These considerations suggest that seeming to incorporate social criteria into solid organ allocation may have the opposite of its intended effect. If what Farrell et al. are claiming is true and membership in a social class is capable of harboring implicit biases, then incorporating social criteria does not necessarily guarantee the just allocation of scarce resources. On the contrary, it may perpetuate these wrongdoings. Thus, it seems far more beneficial and important to incorporate medical criteria, including likelihood of success and medical utility. This was what was attempted by White (2021) in ethical guidelines for allocation of healthcare resources during crisis standards of care:

The allocation framework is also designed to achieve the following: 1. To create meaningful access for all patients. All patients who are eligible for ICU services during ordinary circumstances remain eligible, and there are no exclusion criteria based on age, disabilities, or other factors. 2. To ensure that all patients receive individualized assessments by clinicians, based on the best available objective medical evidence. 3. To ensure that no one is denied care based on stereotypes, assessments of quality of life, or judgments about a person's "worth" based on the presence or absence of disabilities or other factors."

The introduction of social factors may come with a cost, in that it can easily open opportunities for discrimination and unfair allocation determinations. It is far more plausible, and ethically appropriate, to tie medical determination to medical need. In the case of COVID vaccine mandates for SOT, it will be important to show skeptics that this is grounded in clinical criteria anticipating an organ recipient's vulnerability to infection during a lifetime of immunosuppression. Social factors that lead to vaccine hesitancy can be acknowledged, but ultimately the patient being evaluated for transplant listing will need to choose adherence to clinical protocols or choose to not be listed.