

Panorama

Who Are We to Decide That the Unvaccinated Don't Deserve Care?

Cheryl Barnabe , MD, MSc, FRCPC, Professor of Medicine and Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada. Address correspondence to Dr. C. Barnabe, 3330 Hospital Dr NW, Calgary AB T2N4N1, Canada. Email: ccbarnab@ucalgary.ca. CB received speaker's fees from Pfizer, Sanofi Genzyme, Janssen, and Fresenius Kabi; and is on the advisory boards of Celltrion Healthcare and Gilead.

With only a brief interruption in the spring of 2020, I have been fortunate to have excellent access to personal protective equipment and thus continue to primarily provide in-person visits. One particular patient spent most of the appointment time protesting having to wear a mask, expressing how public health restrictions were detrimental to personal freedom, and how ludicrous it was that people could stay at home and not work yet receive Canadian Emergency Response Benefits. These opinions are in direct opposition to my own, yet as the professional, I respectfully listened and then redirected the focus back to the less controversial discussion about their rheumatic disease management. However, we also discussed their view about vaccination and treatment for COVID-19 (coronavirus disease 2019). They expressed on multiple occasions their absolute refusal of any “experimental” treatment, and their preference to die from COVID-19 rather than be “forced” to get the jab.

Within about 6 weeks of that last visit, a COVID ward attending physician called for advice about whether this same unvaccinated patient should receive tocilizumab for management of severe COVID. I said no, not due to a medical contraindication, but because this did not align with the patient's wishes. The physician inferred in our debate that I had not sufficiently counseled the patient about the benefits of COVID-19 vaccination, and that I was now also withholding necessary treatment. My intention, however, was simply to uphold patient autonomy. Sometimes, patient autonomy conflicts with what physicians think is best.

As physicians, we are trained in the biomedical model, prepared to identify the best course of action for patient care based on available evidence. We attend conferences and seminars to enhance our awareness and understanding of new approaches, develop guidelines to inform our practice, and measure our performance to identify where we must rectify deviations from the accepted standards. Despite all these efforts, the evidence and how to apply it in practice is frequently incomplete, particularly as therapeutic clinical trials exclude the medically complex, have low enrollment of persons of diverse backgrounds, or are not required to be completed (such as with biosimilars). Thus, we constantly make inferences and live with some uncertainty about a treatment effect. We have also denounced those fastidiously sticking only to available evidence, such as when we were called on in the advocacy efforts with the National Advisory Committee

on Immunization (NACI) for rheumatology patients to be eligible to receive COVID vaccines despite their exclusion from the trials. The spectrum of evidence we use is then necessarily integrated with patient preferences and beliefs through our individual interactions. When someone doesn't accept our medical advice readily, we react. We provide more information, but frustration mounts. The patient becomes labeled as “noncompliant” (or the more politically correct “nonadherent”), and we continue to schedule visits, waiting for the moment when they come around and fall in line with what we believe is the right choice or decision. If they do, we are relieved, and if they don't, we kindly ask they be re-referred when they are ready to make a treatment decision.

The COVID-19 pandemic ripped off a sticky Band-Aid for us as professionals and humans, intensifying our reactions and leading us to search for where we can control some aspect of our lives. For some, they realized that they really don't love rheumatology, or even medicine, as much as they thought. Careful and systematic actions to address gender gaps in medicine were, in fact, just lipstick on a pig. That our social nature as a profession might in fact be a predisposition to maladaptive coping mechanisms. We are, in truth, judgmental humans. We have given sideways glances and gossiped about colleagues traveling despite recommendations against it, or secretly hosted small parties while critiquing the “idiots” who went ahead with their wedding, which then became a superspreader event.

When it comes to COVID vaccination, an even more extreme discourse has emerged—that we have the right to decline to see unvaccinated patients. Some of us believe strongly in vaccination, public health, and the collective, and we rolled up our sleeves at the first opportunity to do so. We relied on our knowledge that with excellent population protection, we can return to normally scheduled programming. Other physicians may have had initial reservations, but proceeded with vaccination to facilitate travel, entry to venues for entertainment, participation in sport, or to keep their employment. With a truly small minority of physicians refusing vaccination, most of us are in fact a law-abiding bunch, the “sheep,” as the antivaccine movement call us. And so, we don't want to see those unvaccinated patients. To avoid complaints from the regulatory college, we publicly state our practice offers telemedicine, but we are secretly happy to avoid these folks and their extreme views. We cite concerns for

our personal and families' safety, or perhaps argue that we wish to minimize the risk of exposure for our staff and immunosuppressed patients in a waiting room or clinic. We are validated by societal perspective, with the unvaccinated being villainized for prolonging the restrictions put in place to save the health system from implosion. There is most recently the threat of additional taxation for those who are driving up health system use, which is a substantial departure from universal healthcare principles.

Is this debate about the right to decline provision of care actually about our own egos? Are we simply being indignant that there are volumes of evidence about the benefits of vaccination, but that uninformed or radical patients refuse to accept the "right" way of living? Why can't we just accept that personal preferences and views, like evidence, are truly a spectrum? Have we forgotten that our role is to support the patient with their decision making, even if it diverges from what we would do?

As a proud rheumatologist, I worry about what impact we are having on the reputation of our specialty by offering a different standard of care to the unvaccinated. It is a privilege that we have options to select how we follow our patients during the pandemic—think of surgeons, who don't have the ability to turn away patients who need laparotomies, and obstetricians, who still need to deliver babies. Should we be concerned about a potential effect of diminishing the importance of our work, and the need for rheumatology, if we can choose who is and who is not worthy of our care? Are we actually shirking our duty to colleagues in other disciplines by not completely assessing unvaccinated patients, and as a result, is their rheumatic disease unnecessarily active when they require admission for COVID-19 infections?

It is time for us to stop the judgment about the unvaccinated or those declining rheumatic disease therapy, and to start being OK with choices that patients make that conflict with our own beliefs.