

Addressing the Tension between Discrimination Law and Pandemic Clinical Triage Protocols

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- Samuel R. Bagenstos, *May Hospitals Withhold Ventilators from COVID-19 Patients with Pre-Existing Disabilities? Notes on the Law and Ethics of Disability-Based Medical Rationing*, 130 *Yale L. J. Forum* ___ (forthcoming, 2020), available at [SSRN](#).
- Deborah Hellman & Kate Nicholson, *Rationing and Disability in a State of Crisis* (Apr. 16, 2020), available at [SSRN](#).

With the COVID-19 pandemic wreaking havoc in health care systems around the world, many jurisdictions have recently drafted or dusted off old clinical care triage protocols to facilitate decision-making when surges in infection rates overwhelm hospitals' Intensive Care Units (ICUs). Not surprisingly, most of these policies reflect a utilitarian approach. Law and ethics policies generally endorse the notion that a pandemic or other large-scale threat to society requires efficient action by governments, which may involve a curtailing of individual rights. A growing chorus of academic commentators and [human rights organizations](#) have voiced concern that the focus on 'saving the most lives' embedded in triage policies, and particularly how these policies hope to achieve this, clashes with discrimination law, and particularly the rights of people with disabilities. Of a near-tsunami of [blogs](#), [op-eds](#), and commentaries in the legal, [bioethics](#), and medical literature, forthcoming law articles by [Samuel R. Bagenstos](#), and [Deborah Hellman and Kate Nicholson](#) stand out for how they discuss what the demands of equity imposed by discrimination law require, and how they each give us some idea of what accommodation in clinical triage protocol policies could look like.

Triage protocols are intended to solve the clash of commitments among physicians, when they are no longer able to give all patients the care they would normally feel duty-bound to provide. They introduce selection criteria for access to care (particularly ventilators, which I will focus on later), explicitly based on concepts of utility, fairness, proportionality, and reciprocity; and also decision-making procedures built around triage committees. Triage protocols deal with life and death decisions, or a least with who will receive an albeit limited chance of survival, since survival rates of those put on a ventilator for COVID19 appear troublingly low. The disability community has raised particular concerns about those protocols that mention specific disabilities as disqualifying conditions. These concerns flow from a historical experience with deprioritization and broad problems of equitable access to health care; concerns that have been heightened by the disproportionate impact of the pandemic. But even protocols claiming to be purely based on clinical prognoses and prediction of mortality have come under scrutiny because of their disproportionate impact on people with disabilities and other disadvantaged groups.

One of the key questions addressed in the emerging literature is whether, and to what extent, system and public interest-focused triage planning can be reconciled with the equal rights of people with disabilities. Most prominent has been a debate for the *Yale Law Journal Forum* between [Samuel R. Bagenstos](#) and [Govind Persad](#). Both agree on some points: they reject quality of life assessments for triaging, and are concerned about biases and unsupported assumptions about people with disabilities. But Persad supports broad triaging and accepts that some people with disabilities should be deprioritized based on 'evidence-based' assessments of likelihood of benefit. He argues that triage policies are the most efficient way to save more people, including more people with disabilities, as well as more overall "life years"; and that disability advocates should instead focus on reducing the scarcity of ventilators. Bagenstos supports only a limited form of triaging, namely exclusion of people who are unlikely to survive treatment, with other selection criteria such as random selection to prioritize all others.

Bagenstos' discussion focuses on why the use of disabilities as a category for exclusion constitutes discrimination

based on disability under the Americans with Disabilities Act and the Affordable Care Act. He starts with an analysis of the key legal requirements for a finding of discrimination: in order to be protected under the law, a person must fulfill the essential eligibility criteria for life-saving ventilation support (i.e. must be 'qualified' for this form of medical care). Bagenstos highlights the danger of deeming a "comparative ability to benefit" to be a proper qualification standard in triage policies if it excludes people with disabilities from accessing ventilators [based on calculations that their lives are 'worth less'].

In this discussion, he points out how the restrictions imposed by disability law help counter the well-documented influence, in the provision of health care, of 'outside' (read 'ableist') views of the quality of life of people with disabilities. For Bagenstos, objective, well-documented medical evidence that a person with a disability will not benefit at all from receiving ventilator support can be the basis for a legally valid disqualification. He warns, however, that we should remain vigilant even when exclusions are based on medical facts, because distorted estimates of survival chances may insert bias into these 'objective' assessments. He therefore not only calls for a categorical rejection of specific disabilities as a sufficient basis for exclusion, but also pushes for procedural safeguards that protect against biased assessments. As a component of the duty to accommodate under discrimination law, he also suggests that "medical systems [should] take steps to ensure that those who are not qualified for life-saving treatments can become qualified." Of further interest, Bagenstos situates the legitimacy of triage exclusions in the context of the broader goal of discrimination law: compensation for the challenges caused by underrepresentation of people with disabilities among health professionals who control the decision-making process, and for the barriers they face for full participation in democratic processes that shape our health care system.

In a paper focusing on policies that appear neutral (i.e. without any explicit disability-based exclusions), Deborah Hellman and Kate Nicholson go even further than Bagenstos. In *Rationing and Disability in a State of Crisis*, they conclude, albeit "cautiously," that *any* policy that results in excluding people with disabilities from accessing life-saving care fails to satisfy the equity requirement embedded in anti-discrimination law. Like Bagenstos, they rightly situate the debate in the context of the broad purpose of anti-discrimination law, namely rectifying the structural inequities that are built into our society, including in the health care system. The paper stands out for its detailed comparison of the degree of incompatibility between four common rationing principles and the demands of equity that undergrid anti-discrimination law.

Hellman and Nicholson's discussion of the historical use of 'quality of life' is interesting, but less important in this context. Few (if any) current pandemic triage policies put forward post-ventilation quality of life as a criterion for access, and rightly so, since the use of stereotypical ableist quality of life presumptions clearly runs counter to the core goal of anti-discrimination law. The three other key principles they consider (efficiency, probability of success, and life expectancy) are of greater relevance in the present context.

With respect to using life expectancy as a triage criterion, they acknowledge that there are ethical arguments in support of favoring young people over old (providing an opportunity for a full life; and giving the young a fair share of resources). But they rightly point out that policies allowing calculations based on life expectancy (so those that do not just favor young over old) will have a particular and disparate impact on people with disabilities, many of who have shorter life expectancy. A life-expectancy criterion is thus inherently suspect under anti-discrimination law.

Further to this, the authors argue that even efficiency and probability of success, the criteria with the most neutral associations to the core purpose of triaging (saving the most lives), are in tension with discrimination law. Of the two, probability of success of ventilation treatment in individual patients, which is expressed in percentages of survival chances, is most problematic for them because it involves a comparison of two persons who need to be treated as equals. Under anti-discrimination law, treating them as equals requires ensuring a disabled person (who, for example, might only have a 30% chance of survival, compared to another person with a 50% chance) an equal chance of access to a service that may save their life.

For Hellman and Nicholson, triaging based on efficiency is morally preferable because it does not amount to explicitly

weighing the life of one person in need of care against another's. For instance, efficiency aims to provide ventilator support to more people, by favoring those who are more likely to benefit quickly. Although both ultimately save more lives and are somewhat similar in outcome (and in my view overlap significantly—I still have difficulty disentangling the two in some practical examples, and I think they will most often be jointly used), efficiency is based on statistical numbers: how many will benefit, not which of the two people before us will most likely benefit. It thus constitutes a less direct disadvantage for people with disabilities. However, Hellman and Nicholson conclude that even efficiency-focused protocols risk running counter to the duty to accommodate that is embedded in discrimination law, for instance when they fail to take into consideration that people with a disability may require more time on a ventilator than a neutral efficiency-based time limit would allow.

Both the Hellman and Nicholson and Bagenstos papers recognize that discrimination law leaves room for some level of efficiency and practicality, though they seem to slightly disagree on how to balance these with the duty to accommodate. Both also discuss anti-discrimination law's discomfort with broad categorizations, and its emphasis on the need for individualized assessments, which are needed to allow individuals to escape the statistics that would otherwise categorically exclude them from access to care. One particularly compelling aspect of their analysis lies in their emphasis that the approach of 'saving more lives,' embedded in triage policies, is fundamentally in tension with the ameliorative purpose of discrimination law. This is an implicit rebuttal to those who suggest that since more people with disabilities will benefit from efficient triage policies than be harmed, triaging focused on saving most lives is fundamentally compatible with anti-discrimination law. Indeed, the concept of equity embedded in discrimination law requires us to look beyond a mere utilitarian calculation of degree of benefit and numbers of people benefiting. They impose a duty to consider how to compensate for structural inequities in the first place.

But how far we can and should go with accommodation in relation to access to ventilators remains to be further explored. Are there other ways than the example Hellman and Nicholson give of permitting a person with disabilities more time on a ventilator if that will provide the person a fair chance of survival? When does accommodation become so unpractical that it really undermines the ability of the health care system to reasonably cope with a shortage? For instance, a recent paper in the [medical literature](#) makes an interesting suggestion to compensate for the broader background inequity in health care by "weighing triage scores with an area deprivation index that accounts for social determinants of health." That would accommodate many people living in communities (particularly in large urban centers) that have been disproportionately affected by the pandemic, and seems to align with the demand for equity. Could there be a similar scale that accounts for the broader inequities that many people with disability face? Such a score could be part of an ameliorative scheme for people with disabilities that may compensate for the lower priority score on triage policies that they would otherwise receive. But do these suggestions not risk becoming so unpractical that they exceed what accommodation can require? Will they even be concretely implemented? In conversations I had with emergency physicians on the topic of pandemic triage protocols, the message was that if protocols become too complicated, physicians will find a way around them, particularly when the rubber hits the road. The authors of the papers discussed here appropriately emphasize that we have to accommodate people with disabilities, even within a context of pandemic triaging. But more work can and needs to be done in thinking about the concrete implementation of accommodation measures.

The papers discussed here will undoubtedly inspire those with a particular interest in disability rights and pandemic health care policies. But they should also be of interest to all those thinking about the relation between individual health rights and broader health systems planning.

Trudo Lemmens, *Addressing the Tension between Discrimination Law and Pandemic Clinical Triage Protocols*, JOTWELL (July 8, 2020) (reviewing Samuel R. Bagenstos, *May Hospitals Withhold Ventilators from COVID-19 Patients with Pre-Existing Disabilities? Notes on the Law and Ethics of Disability-Based Medical Rationing*, 130 *Yale L. J. Forum* __ (2020); Deborah Hellman & Kate Nicholson, *Rationing and Disability in a State of Crisis*, available at [SSRN](#)), <http://health.jotwell.com/addressing-the-tension-between-discrimination-law-and-pandemic-clinical-triage-protocols>.