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Disability Law and the Case for Evidence-Based Triage in a Pandemic

Govind Persad

ABSTRACT. This Essay explains why model policies proposed or adopted in response to the COVID-19 pandemic that allocate scarce medical resources by using medical evidence to pursue two core goals—saving more lives and saving more years of life—are compatible and consonant with disability law. Disability law, properly understood, permits considering medical evidence about patients’ probability of surviving treatment and the quantity of scarce treatments they will likely use. It also permits prioritizing health workers, and considering patients’ post-treatment life expectancy. These factors, when based on medical evidence and not inaccurate stereotypes, are legal to consider even if they disadvantage some patients with specific disabilities.

It then discusses the ethical advantages of triage policies that use medical evidence to save more lives and years of life, which I call “evidence-based triage,” focusing on the benefits of these policies for patients with disabilities. In doing so, I explain why recent critiques err by treating people with disabilities as a monolith, overlooking the political disadvantages of less-visible victims, and treating the social origins of scarcity as a justification for saving fewer lives. Evidence-based triage parallels other policy responses to the COVID-19 pandemic, like physical distancing and postponement of medical procedures, which may burden patients with specific disabilities or medical conditions but are nevertheless justified because they save more patients.

INTRODUCTION

The rapid spread of COVID-19 in the United States, fueled by a haphazard federal response, has led to a scarcity of potentially lifesaving treatments for COVID-19 patients. This scarcity has prompted states to develop or revise plans for fairly distributing access to these treatments. And it has prompted articles in

high-profile medical journals delineating principles for fair allocation of ventilators, intensive-care beds, therapeutics, and other scarce treatments,¹ and the development of model triage guidelines for hospitals.² These proposals agree on the importance of saving more lives, saving more years of life, and not using quality-of-life judgments.³ They aim to save more lives by prioritizing frontline health workers who can then return to helping others, and by prioritizing patients who can benefit most from treatment – patients who are neither so healthy that they will likely recover without the scarce treatment, nor so ill that they are unlikely to recover even with it.⁴

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1. See, e.g., Ezekiel J. Emanuel, Govind Persad, et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 *NEW ENG. J. MED.* 2049 (2020); Douglas B. White & Bernard Lo, *A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic*, 323 *JAMA* 1773 (2020).
 2. Douglas B. White et al., *Allocation of Scarce Critical Care Resources During a Public Health Emergency*, U. PITT. (Apr. 15, 2020), https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy_2020_04_15.pdf [<https://perma.cc/L5CK-AA4C>].
 3. Importantly, they also agree that saving more years of life is a lower-priority and more constrained aim than saving more lives. See White et al., *supra* note 2, at 1773; Emanuel et al., *supra* note 1, at 2052.
 4. Emanuel et al., *supra* note 1, at 2052 (stating that, under their approach, “people who are sick but could recover if treated are given priority over those who are unlikely to recover even if treated and those who are likely to recover without treatment”).

The proposed adoption of these and other triage guidelines has prompted criticism.⁵ Some critics focus on state guidelines that use “quality of life” judgments, a criticism I endorse.⁶ But many also reject methods of triage that aim only to save more lives and years of life. Critics of triage instead urge alternative solutions such as:

1. *Random selection*: Selecting patients by lottery,⁷ or first come, first served,⁸ without regard to their prospect of benefit.
2. *Minimal triage*: Considering only whether a patient can benefit, irrespective of likelihood or magnitude of benefit, or the likely quantity of resources required for benefit.⁹

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5. See, e.g., Samuel R. Bagenstos, *Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols*, 130 YALE L.J.F. 1 (2020); Deborah Hellman & Kate Nicholson, *Rationing and Disability in a State of Crisis* (Va. Pub. Law & Legal Theory Research Paper No. 2020-33, 2020), <https://ssrn.com/abstract=3570088> [<https://perma.cc/CE5L-NDUK>]; Colin Killick & Marlene Sallo, Letter, *Disability Community Will Fight Any Attempt to Discriminate over Scarce Medical Resources*, BOS. GLOBE (Mar. 17, 2020, 5:12 PM), <https://www.bostonglobe.com/2020/03/18/opinion/disability-community-will-fight-any-attempt-discriminate-over-scare-medical-resources> [<https://perma.cc/8ZR7-ZMQ8>]; Ari Ne’eman, Opinion, ‘I Will Not Apologize for My Needs’, N.Y. TIMES (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/opinion/coronavirus-ventilators-triage-disability.html> [<https://perma.cc/84A2-HFF9>]; *Preventing Discrimination in the Treatment of COVID-19 Patients: The Illegality of Medical Rationing on the Basis of Disability*, DISABILITY RTS. EDUC. & DEF. FUND (Mar. 25, 2020), <https://dredf.org/wp-content/uploads/2020/03/DREDF-Policy-Statement-on-COVID-19-and-Medical-Rationing-3-25-2020.pdf> [<https://perma.cc/FTS7-JN3S>] [hereinafter *Preventing Discrimination*]; Letter from David Carlson, Dir. of Advocacy of Disability Rights, Disability Rights Wash., to Roger Severino, Dir., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., (Mar. 23, 2020), https://www.centerforpublicrep.org/wp-content/uploads/2020/03/OCR-Complaint_3-23-20-final.pdf [<https://perma.cc/3A93-NK4P>] [hereinafter *Washington Complaint*].
 6. See, e.g., Bagenstos, *supra* note 5; Ne’eman, *supra* note 5; *Preventing Discrimination*, *supra* note 5; see also Emanuel et al., *supra* note 1, at 4 (recommending “against incorporating patients’ future quality of life, and quality-adjusted life-years” into triage guidelines); White et al., *supra* note 2, at 2 (excluding “assessments of quality of life”). I therefore agree, for instance, with criticisms of recent state triage policies that categorically exclude certain patients who need assistance with activities of daily living. See Michelle M. Mello, Govind Persad & Douglas B. White, *Respecting Disability Rights – Toward Improved Crisis Standards of Care*, NEW ENG. J. MED. (2020), <https://www.nejm.org/doi/full/10.1056/NEJMp2011997> [<https://perma.cc/8NH9-53H8>].
 7. Bagenstos, *supra* note 5, at 4. Bagenstos believes a lottery is permissible, though not required.
 8. Ne’eman, *supra* note 5; *Preventing Discrimination*, *supra* note 5, at 9.
 9. See Bagenstos, *supra* note 5, at 12, 15; *Preventing Discrimination*, *supra* note 5, at 8; Killick & Sallo, *supra* note 5 (“Should hospitals prioritize those with the least resource-intensive needs or exclude from access to life-sustaining care those with lower survival probabilities, they would be engaging in discrimination.”).

This Essay argues that triage guidelines that use medical evidence about patients' prospect of benefit to pursue the twin aims of saving more lives and more years of life (which I call "evidence-based triage") are legally and ethically preferable to random selection or minimal triage.¹⁰ I argue that evidence-based triage is fully consistent with recognizing the legal and moral equality of each person and emphasizing our duties to the most vulnerable.

In Part I, I explain why the two core goals of evidence-based triage – saving more lives and saving more years of life – are compatible, and even consonant, with disability law. In Part II, I discuss normative arguments for evidence-based triage, highlighting the argument that evidence-based triage will benefit many patients with disabilities, and is even likely to save more patients with disabilities than random selection or minimal triage would. While random selection or minimal triage have the surface appearance of equity, they prevent individualized assessment of each patient's medical situation, leading to worse outcomes for many patients with disabilities and ignoring relevant differences between disabilities. Although I present these Parts together, the doctrinal points in Part I do not require the correctness of the normative claims in Part II, nor do those normative claims depend on the persistence of the legal precedents Part I describes.

I. WHY EVIDENCE-BASED TRIAGE IS LEGAL

In this Part, I defend the legality of evidence-based triage, focusing first on saving more lives and then on saving more years of life. As an initial matter, recent Department of Health and Human Services (HHS) guidance does not preclude evidence-based triage. Rather, it distinguishes relevant and irrelevant considerations, stating that "persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities," and that decisions "concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence."¹¹ Stereotypes and judgments of relative worth not only risk unfairness to patients with disabilities – they hinder

10. The model guidelines discussed at the outset exemplify evidence-based triage. See White et al., *supra* note 2. As I explain below, evidence-based triage does not use quality-of-life judgments and does not exclude people merely on the basis that they have a disability; rather, it makes individualized judgments.

11. Office of Civil Rights, *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)*, U.S. DEP'T HEALTH & HUM. SERVS. 1 (Mar. 28, 2020) <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf> [<https://perma.cc/T4SQ-VRZK>] [hereinafter *Bulletin*].

efforts to save more lives and years of life by introducing irrelevant considerations. I likewise agree with HHS and with disability advocates that quality-of-life judgments are likely to incorporate unjust biases that preclude their use in pandemic triage.¹²

In contrast, the aim of saving more lives is widely championed in COVID-19 response both inside and outside triage contexts.¹³ Wide cross sections of both laypeople and theorists endorse it.¹⁴ Both this aim and that of saving more years

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12. Some have proposed strategies for incorporating quality-of-life determinations into health policy while combating bias. *E.g.*, Anirban Basu, Josh Carlson & David Veenstra, *Health Years in Total: A New Health Objective Function for Cost-Effectiveness Analysis*, 23 *VALUE HEALTH* 96, 98 (2020); Nir Eyal, *Measuring Health-State Utility via Cured Patients*, in *DISABILITY, HEALTH, LAW, AND BIOETHICS* 266, 266-79 (I. Glenn Cohen et al. eds., 2020); Govind Persad, *Considering Quality of Life While Repudiating Disability Injustice: A Pathways Approach to Setting Priorities*, 47 *J.L. MED. & ETHICS* 294, 300-01 (2019). But these newer approaches are better suited to setting health system priorities than comparing individuals, and would require data collection that is impractical in a pandemic. See Emanuel et al., *supra* note 1, at 4.
 13. See, *e.g.*, *FAQ for DHHS Omnibus EO*, N.C. OFF. GOVERNOR 1 (Apr. 9, 2020), <https://files.nc.gov/governor/documents/files/FAQ-for-DHHS-Omnibus-EO.pdf> [<https://perma.cc/9WWE-PKHJ>] (“The actions taken by this Order allow for . . . transfer [of] medical resources where they can be most effective and save the most lives.”); *Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic*, NAT’L ACAD. SCI., ENGINEERING & MED. 1 (Mar. 28, 2020), <https://files.asprtracie.hhs.gov/documents/nap-rapid-expert-consultation-on-csc-for-covid-19-pandemic.pdf> [<https://perma.cc/GJ5W-C2TG>] (noting that crisis standards of care “strive to save the most lives possible”); *New Mexico COVID-19 Update: One Death*, ST. N.M. (Mar. 25, 2020), <https://www.newmexico.gov/2020/03/25/new-mexico-covid-19-update-one-death> [<https://perma.cc/V6NL-WKDJ>] (stating that “[s]ocial distancing and isolation” are needed “to save more lives and prevent more deaths”); *COVID-19 Update: Congregate Care Unified Response Teams*, OHIO DEP’T HEALTH (May 26, 2020), <https://coronavirus.ohio.gov/wps/portal/gov/covid-19/resources/news-releases-news-you-can-use/congregate-care-response> [<https://perma.cc/HY4J-2BNJ>] (statement of Gov. Mike DeWine) (“As we continue to ramp up our testing in Ohio, we must deploy our resources in a way that will save the most lives.”); *Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Briefing*, U.S. WHITE HOUSE (Apr. 5, 2020), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-19> [<https://perma.cc/55K6-RS6W>] (statement of Dr. Deborah Birx) (praising the “healthcare workers who are doing every single thing humanly possible to save more lives”).
 14. See sources *infra* Part II and notes 70-74 (describing the endorsement of saving more lives by laypeople and by numerous non-utilitarian ethicists). Notably, while utilitarian ethicists may often prefer saving more lives over random selection or minimal triage, saving more lives is not utilitarian. See Julian Savulescu, James Cameron & Dominic Wilkinson, *Equality or Utility? Ethics and Law of Rationing Ventilators*, *BRIT. J. ANAESTHESIA* (Apr. 20, 2020), [https://bjanaesthesia.org/article/S0007-0912\(20\)30223-3/fulltext](https://bjanaesthesia.org/article/S0007-0912(20)30223-3/fulltext) [<https://perma.cc/Y777-478D>] (explaining that utilitarianism requires considering quality of life, and criticizing as non-utilitarian an approach that maximizes “the numbers of lives saved”). *Contra* Hellman & Nicholson, *supra* note 5, at 1 (claiming that saving “as many lives as possible” is a “fully utilitarian

of life can be pursued without reliance on unfair classifications; pursuing these goals only requires recognizing the equal value of all patients' lives, and of every year within those lives.¹⁵ Notably, the HHS Office of Civil Rights closed a civil-rights complaint against the Pennsylvania Department of Health as satisfactorily resolved after Pennsylvania removed language that singled out specific disabilities and added language about individualized assessments; the revised guidelines continue to incorporate assessments of patients' prospect of benefit with the aim of saving more lives and years of life.¹⁶

Although there is little precedent applying disability law to the allocation of scarce, lifesaving treatments, organ allocation is the closest analogy. Organ allocation policies align more closely with evidence-based triage than do random selection or minimal triage. Most notably, lung allocation policy considers candidates' probability of post-transplant survival.¹⁷ Kidney allocation policy also considers survival, and allocation policies for all organs consider medical factors that affect survival, such as immunological matching.¹⁸ Legal precedent also recognizes that probability of survival is a legitimate basis for organ allocation.¹⁹

approach”). Saving more lives certainly is not the “ruthless utilitarianism” criticized by the Office of Civil Rights. See *Bulletin*, *supra* note 11.

15. Cf. Wendy F. Hensel & Leslie E. Wolf, *Playing God: The Legality of Plans Denying Scarce Resources to People with Disabilities in Public Health Emergencies*, 63 FLA. L. REV. 719, 759 (2011) (supporting the use of the Sequential Organ Failure Assessment scoring system in pandemic triage and noting that “the use of medical effectiveness in this manner is not based on stereotypes, generalizations, or myths about disabilities”).
16. See HHS Press Office, *OCR Resolves Civil Rights Complaint Against Pennsylvania After It Revises Its Pandemic Health Care Triage Policies to Protect Against Disability Discrimination*, U.S. DEP’T HEALTH & HUMAN SERVS. (Apr. 16, 2020), <https://www.hhs.gov/about/news/2020/04/16/ocr-resolves-civil-rights-complaint-against-pennsylvania-after-it-revises-its-pandemic-health-care.html> [<https://perma.cc/E2R4-EXR5>]; *Interim Pennsylvania Crisis Standards of Care for Pandemic Guidelines, Version 2*, PA. DEP’T HEALTH & HOSP. & HEALTHSYSTEM ASS’N PA., 29-31 (Apr. 10, 2020), <https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID-19%20Interim%20Crisis%20Standards%20of%20Care.pdf> [<https://perma.cc/UZ6S-MJTV>].
17. Organ Procurement and Transplantation Network, *How Organ Allocation Works*, U.S. DEP’T. HEALTH & HUMAN SERVS., <https://optn.transplant.hrsa.gov/learn/about-transplantation/how-organ-allocation-works> [<https://perma.cc/HC8V-5QXF>]. Notably, the National Council on Disability’s recent report neither criticized the use of survival probabilities in organ allocation nor advocated for the use of a “first-come, first-serve” system, but instead emphasized that organ allocation must be based on medical evidence, not stereotypes or quality-of-life judgments about patients with disabilities. *Organ Transplant Discrimination Against People with Disabilities*, NAT’L COUNCIL ON DISABILITY 45 (Sept. 25, 2019), https://ncd.gov/sites/default/files/NCD_Organ_Transplant_508.pdf [<https://perma.cc/L8SZ-SRL9>] [hereinafter *Organ Transplant Discrimination*].
18. *How Organ Allocation Works*, *supra* note 17.
19. *Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 417 (9th Cir. 1994) (concluding that it is legitimate for “doctors, as part of their professional responsibility,” to pursue “distribution

These precedents support applying a similar approach to allocating scarce COVID-19 treatments.

A. Individualized Judgments

Cases applying the Americans with Disabilities Act (ADA) to medical decisions made in nonscarce contexts have often required individualized determinations,²⁰ though distinguished scholars recognize that disability law “does not always require an individualized inquiry.”²¹ In a pandemic, the time needed to make individualized judgments may itself be scarce,²² although HHS asserts that pandemic triage decisions must nevertheless be individualized.²³

Even if we assume, with HHS, that individualized judgments are required in pandemic triage, this counts for—not against—evidence-based triage, which employs individualized determinations.²⁴ In contrast, individualization arguably prohibits random selection, which ignores medical differences between individual patients.²⁵ In practice, random selection is also susceptible to biased or arbitrary decisions, because it requires initial decisions regarding who is eligible for

of livers to patients with the best chances of survival” and that “[p]oor survival rate is an acceptable medical criterion”); *Neal v. Christopher & Banks Comprehensive Major Med. Plan*, 651 F. Supp. 2d 890, 909-10 (E.D. Wis. 2009) (holding that the “concern that livers be distributed to patients with the best chances of survival is an acceptable medical criterion”); *Barnett v. Kaiser Found. Health Plan, Inc.*, No. C-92-4908 SBA, 1993 WL 738364, at *7 (N.D. Cal. Feb. 5, 1993) (observing that “[e]very expert who testified agreed that it is necessary and appropriate to consider available resources at some level in making medical judgments in order to maximize the effective utilization of resources and the survival of patients,” and that even the plaintiff’s expert “testified that he would deny transplants to patients with less than a twenty percent chance of long-term survival even if it was the only treatment available to save the life”), *aff’d*, 32 F.3d 413 (9th Cir. 1994).

20. See, e.g., *Sch. Bd. v. Arline*, 480 U.S. 273, 287 (1987); *Lesley v. Chie*, 250 F.3d 47, 55 (1st Cir. 2001); *Sumes v. Andres*, 938 F. Supp. 9, 11-12 (D.D.C. 1996).
21. Hensel & Wolf, *supra* note 15, at 762; see also Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 516 (1995).
22. See Hensel & Wolf, *supra* note 15, at 761-62 (analyzing and identifying support for, but not endorsing, this claim); cf. *Lockett v. Catalina Channel Express, Inc.*, 496 F.3d 1061, 1067 (9th Cir. 2007) (upholding a time-pressured decision to exclude a disabled person from a ferry lounge based on a reasonable, but non-expert, risk assessment).
23. See *Bulletin*, *supra* note 11, at 1.
24. Hensel & Wolf, *supra* note 15, at 759 (noting that triage guidelines that employ an evidence-based scoring system “involve the individualized consideration missing from the categorical denials that run afoul of the [Americans with Disabilities Act (ADA)]”); see White et al., *supra* note 2, at 1 (emphasizing the need for individualized assessments).
25. Cf. *Watson v. Navistar Int’l Transp. Corp.*, 827 P.2d 656, 665 (Idaho 1992) (quoting *Beakley v. Optimist Printing Co.*, 152 P. 212, 214 (Idaho 1915) (“A gambling verdict, such as pitching a coin or using some other gambling means to determine the result of a trial, is unacceptable

selection but offers no guidance in making these judgments.²⁶ While triage policies should recognize that medical professionals may be biased against patients with disabilities,²⁷ the solution is not to encourage unguided eligibility decisions under time pressure, which are more likely to be biased or arbitrary.²⁸ The better option is to employ triage policies that constrain and guide decisions by requiring that they be justified using consistently applied medical criteria.²⁹ Evidence-based triage can reduce arbitrariness by ensuring that triage decisionmakers only have access to medically relevant information and are not privy to medically irrelevant and potentially biasing details, like a patient's name, gender, race, nationality, or disabilities that are irrelevant to COVID-19 treatment.³⁰

B. Saving More Lives

In this Section, I argue that disability law permits triage approaches that use medical evidence, including evidence about disabilities that affect a patient's chances of survival or the quantity of resources they will require, to pursue the goal of saving more patients. This approach diverges from the view that a patient's disability may only be considered if they "will die in the immediate term from that disability with or without that treatment," and that triage guidelines may not deny "treatments to individuals because of their disabilities, when those individuals can benefit from them," irrespective of potentially large differences in probability of benefit.³¹ Medicine is permitted to save the most lives, even when other available options would not be futile.

because 'there is no discussion or consideration of the merits by the jury.'"); Carol Necole Brown, *Casting Lots: The Illusion of Justice and Accountability in Property Allocation*, 53 BUFF. L. REV. 65, 113-14 (2005) (criticizing lottery allocation).

26. Brown, *supra* note 25, at 126 & n.265 (quoting JON ELSTER, SOLOMONIC JUDGMENTS: STUDIES IN THE LIMITATIONS OF RATIONALITY 67 (1989) ("I know of no instance of social lotteries without some preselection or postselection scrutiny on the basis of need, merit and the like.")).
27. Bagenstos, *supra* note 5, at 9 & n.31.
28. Cf. Irene V. Blair et al., *An Investigation of Associations Between Clinicians' Ethnic or Racial Bias and Hypertension Treatment, Medication Adherence and Blood Pressure Control*, 29 J. GEN. INTERNAL MED. 987, 993 (2014) ("Implicit bias may be more likely to affect care . . . in decisions made under time pressure, with limited information or without the benefit of clear guidelines.").
29. *Id.*
30. See Mello, Persad, & White, *supra* note 6, at 4.
31. Bagenstos, *supra* note 5, at 20, 25.

1. *Considering Probability of Survival*

Some patients may have a lower probability of survival than others due to specific disabilities. Before defending minimal triage, Samuel Bagenstos concedes that “an individual’s disability may make it impossible or impracticable for them to satisfy certain eligibility criteria, even if the criteria are defined with no reference to disability,”³² and illustrates this via the example of a blind bus driver. Because blindness completely prevents safe driving, not hiring blind drivers is legal. But the bus driver analogy also justifies considering disabilities that make safe driving less probable, such as color blindness or epilepsy.³³ The same should be true for disabilities that affect survival but do not make treatment futile.

Bagenstos argues that because the goal of rationing treatment is not universally agreed upon, appropriate eligibility criteria for scarce treatments are difficult to discern.³⁴ But saving lives is a core goal of medicine and of COVID-19 response in particular, unlike maximizing the “prospective economic output of those we save.”³⁵ It is endorsed in case law discussing the distribution of other scarce treatments, most notably transplants.³⁶ It requires no judgments about the value of life with a disability.³⁷

It is plausible – though contestable – that decisions about which patients will receive scarce medical treatments are governed by disability discrimination law.³⁸

32. *Id.* at 8.

33. See, e.g., *Shannon v. N.Y.C. Transit Auth.*, 332 F.3d 95, 102 (2d Cir. 2003) (upholding color differentiation as an essential qualification for driving a bus under the ADA); *Ward v. Skinner*, 943 F.2d 157, 159 (1st Cir. 1991) (denying a procedural challenge to a general agency rule forbidding epileptic truck drivers).

34. Bagenstos, *supra* note 5, at 7-10.

35. *Id.* at 8. Bagenstos does not identify triage guidelines that consider, or aim to maximize, patients’ economic output.

36. Regarding transplants, see *supra* note 19. Regarding other resources, see, for example, *Estate of Cole v. Fromm*, 941 F. Supp. 776, 784 (S.D. Ind. 1995), *aff’d*, 94 F.3d 254 (7th Cir. 1996), which permits the allocation of scarce suicide-prevention resources to patients at highest risk, and *Henderson v. Tanner*, No. CV 15-804-SDD-EWD, 2019 WL 885914, at *11 (M.D. La. Feb. 22, 2019), which discusses federal guidelines for prisoners’ access to scarce Hepatitis C medications, which “reflect the balancing of limited resources and the need for medical treatment by prioritizing the greatest medical need and the highest likelihood of success for each given patient.”

37. Cf. Hensel & Wolf, *supra* note 15, at 759 (supporting the use of the Sequential Organ Failure Assessment scoring system in pandemic triage and noting that “the use of medical effectiveness in this manner is not based on stereotypes, generalizations, or myths about disabilities”).

38. Compare Bagenstos, *supra* note 5, at 6-7 (arguing that the ADA applies to medical treatment decisions), with *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1289, 1294 (11th Cir. 2005) (“The Rehabilitation Act, like the ADA, was never intended to apply to decisions involving the termination of life support or medical treatment.”), *Burger v. Bloomberg*, 418 F.3d 882, 883 (8th

But the cases finding that providers have illegally discriminated involve groundless judgments or invidious stereotypes, not factually grounded prediction. The Supreme Court's ruling against a provider who refused to treat a patient with HIV rested on the provider's failure to provide "objective, scientific information" that would make refusal "reasonable in light of the available medical evidence."³⁹ Lower court opinions likewise differentiate groundless or biased decisions from those grounded in legitimate, even if disputable, medical evidence.⁴⁰ And courts resolve uncertainty in favor of medical decisionmakers who are making good-faith efforts to ground their decisions in evidence.⁴¹

2. Considering Quantity of Resources Required

Patients with certain disabilities may require more of a scarce treatment than others do. The American Medical Association recognizes this may be a legitimate medical consideration in absolute scarcity.⁴² Yet some recent disability advocacy rejects it.⁴³

Cir. 2005) (per curiam) ("[A] lawsuit under the Rehab Act or the [ADA] cannot be based on medical treatment decisions."), and Sharon Hoffman, *Preparing for Disaster: Protecting the Most Vulnerable in Emergencies*, 42 U.C. DAVIS L. REV. 1491, 1525 (2009) ("Precedent establishes that patients will not be successful in suing healthcare providers for ADA or Rehabilitation Act violations relating to good-faith medical treatment decisions.").

39. *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998).
40. See, e.g., *McGugan v. Aldana-Bernier*, 752 F.3d 224, 234 (2d Cir. 2014); *Lesley v. Chie*, 250 F.3d 47, 58 (1st Cir. 2001); *Onishea v. Hopper*, 171 F.3d 1289, 1299 (11th Cir. 1999) (en banc); *Sumes v. Andres*, 938 F. Supp. 9, 12 (D.D.C. 1996); *Woolfolk v. Duncan*, 872 F. Supp. 1381, 1390-91 (E.D. Pa. 1995).
41. *McGugan*, 752 F.3d at 234; *Lesley*, 250 F.3d at 58. This point is relevant to concerns that evidence-based triage approaches may lead to mistakes due to limited evidence. See Bagenstos, *supra* note 5, at 20. It is important to work to improve the accuracy of evidence-based approaches, but they need not be perfect to be legal. This is so in particular because a resource that does not go to one patient will benefit another. Where, as in the allocation of medical resources, the interests of potential beneficiaries are balanced such that they "share the risk of error in roughly equal fashion," it is appropriate to use a preponderance-of-evidence approach, rather than a heightened standard that "expresses a preference for one side's interests." See *Herman & MacLean v. Huddleston*, 459 U.S. 375, 390 (1983) (quoting *Addington v. Texas*, 441 U.S. 418, 423 (1979)). The allocation of scarce medical resources among individuals is not analogous to contexts, like the criminal law or civil commitment, where a single individual's established interests conflict with those of a governmental actor. See *Addington*, 441 U.S. at 427.
42. *Allocating Limited Health Care Resources: Code of Medical Ethics Opinion 11.1.3*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/allocating-limited-health-care-resources> [<https://perma.cc/VHE7-CY65>] [hereinafter *Allocating Limited Health Care Resources*].
43. See, e.g., *Killick & Sallo*, *supra* note 5 ("Should hospitals prioritize those with the least resource-intensive needs or exclude from access to life-sustaining care those with lower survival

Several disability law precedents are consistent with considering the quantity of resources a patient is likely to require. The first is *Alexander v. Choate*, which permits the provision of an equal quantum of resources to all patients, even if this produces unequal outcomes for patients with specific disabilities.⁴⁴ The second is *Olmstead v. L.C.*, which concludes that limited resources can justify refusing to maximally accommodate people with specific disabilities when doing so would deprive others – including people with other disabilities – whom the state is also bound to protect.⁴⁵ The third is precedent defining reasonable accommodation: disability law does not require “an accommodation that would result in other employees having to work harder or longer.”⁴⁶ The fourth is the permission provided in disability law to exclude a person from a program in order to protect others’ health or lives.⁴⁷ In explaining this doctrine, courts state that disability law aims to counter “prejudice, stereotypes, or unfounded fear,”⁴⁸ while giving appropriate weight to genuine threats to others’ health and safety, and that “the need to protect public health may at times outweigh the rights of disabled individuals.”⁴⁹

Bagenstos argues that providers should be required to “take steps to ensure that those who are not qualified for life-saving treatments can become qualified.”⁵⁰ Patients with disabilities should of course receive nonscarce resources

probabilities, they would be engaging in discrimination.”); *Preventing Discrimination*, *supra* note 5, at 8 (similar).

44. 469 U.S. 287, 303 (1985) (upholding a state’s Medicaid policy that guaranteed fourteen days of inpatient treatment to all patients, rejecting the view that Medicaid entitles each patient to “that level of health care precisely tailored to his or her particular needs,” and concluding that Medicaid benefits need not be altered to respond to the greater medical needs of patients with specific disabilities); *cf.* Bagenstos, *supra* note 5, at 21 (conceding that Health and Human Services (HHS) endorses consideration of “the cost of medical procedures, the length of hospital stays, prevention of death, and prevention of contagious diseases” (quoting *ADA Analyses of the Oregon Health Care Plan*, 9 ISSUES L. & MED. 397, 411 (1994))). Although *Choate* is a Rehabilitation Act rather than an ADA case, it is often regarded as applicable to the ADA as well. *See e.g.*, *Theriault v. Flynn*, 162 F.3d 46, 48 & n.3 (1st Cir. 1998); Mark C. Weber, *Disability Discrimination by State and Local Government: The Relationship Between Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act*, 36 WM. & MARY L. REV. 1089, 1115 (1995).
45. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 604 (1999) (plurality opinion) (permitting a state to show that “in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities”).
46. *Turco v. Hoechst Celanese Corp.*, 101 F.3d 1090, 1094 (5th Cir. 1996).
47. *See, e.g.*, *Doe v. Woodford Cty. Bd. of Educ.*, 213 F.3d 921, 925 (6th Cir. 2000).
48. *Sch. Bd. v. Arline*, 480 U.S. 273, 287-88 (1987).
49. *Woodford*, 213 F.3d at 925 (quoting *Montalvo v. Radcliffe*, 167 F.3d 873, 876 (4th Cir. 1999)).
50. Bagenstos, *supra* note 5, at 21 n.82.

that help them become qualified. But whether they, or any patient, should receive scarce resources to become qualified requires an evidence-based determination of whether doing so risks depriving other patients, including patients with other disabilities, of needed resources.⁵¹

3. *Considering Ability to Benefit Others*

Evidence-based triage also typically prioritizes healthcare workers.⁵² Doing so helps save more patients, especially those whose illnesses or disabilities make them likelier to require the assistance of skilled professionals. Although random selection and minimal triage would prohibit this prioritization, such a prohibition lacks legal support. Prioritizing healthcare workers, even if they are less likely to be disabled than others,⁵³ does not constitute illegal discrimination, because prioritizing healthcare workers is “necessary for the provision” of scarce treatments.⁵⁴

C. *Saving More Years of Life*

The American Medical Association’s discussion of fairly allocating scarce resources encompasses duration of benefit as well as likelihood of benefit.⁵⁵ Importantly, evidence-based predictions about the number of years a patient can gain from treatment fundamentally differ from subjective judgments about qual-

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51. *Cf. Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131, 138-39 (2d Cir. 1995) (providing an example of a “modification” that “would be unreasonable because of its excessive costs,” and explaining that the “nature and cost” of an accommodation are relevant when assessing whether it is legally required).
52. *See, e.g., Emanuel et al., supra* note 1, at 5; *White et al., supra* note 2, at 8.
53. *See Bagenstos, supra* note 5, at 12 (describing the underrepresentation of people with disabilities among medical professionals).
54. 28 C.F.R. § 35.130(b)(8) (2019). While there are no cases applying this provision to triage policies that prioritize healthcare workers, courts have interpreted it to uphold, for instance, academic requirements for trainee health workers against disability discrimination challenges. *See Maples v. Univ. of Tex. Med. Branch at Galveston*, 901 F. Supp. 2d 874, 883-84 (S.D. Tex. 2012) (“Requiring high standards for future physician assistants is necessary for the proper treatment of patients.”), *aff’d*, 524 F. App’x 93 (5th Cir. 2013). The availability of healthcare workers is similarly necessary for proper patient care.
55. *Allocating Limited Health Care Resources, supra* note 42. The goal of lengthening lives is also adopted in organ allocation policy. *See Organ Procurement and Transplantation Network, Board Approves Enhanced Liver Distribution System*, U.S. DEP’T. HEALTH AND HUMAN SERVICES, <https://optn.transplant.hrsa.gov/news/board-approves-enhanced-liver-distribution-system> [<https://perma.cc/FG2U-HGGA>] (praising a policy revision that “puts more appropriate emphasis on medical criteria that save and lengthen lives”).

ity of life. A patient’s unique perspective on their own quality of life merits deference.⁵⁶ But patients lack similar expertise regarding their future lifespan. Life-expectancy ranges can be predicted for patients with certain illnesses or disabilities,⁵⁷ based on verifiable outcomes – how many patients with a given condition survive for a specified length of time – rather than on subjective, unverifiable beliefs.⁵⁸ Short- and long-term life-expectancy predictions are central to damages calculations in tort cases.⁵⁹ Shorter-term predictions are employed to determine eligibility for scarce antiviral treatments⁶⁰ and hospice care,⁶¹ as well as to prioritize patients for access to experimental treatments and consultations about end-

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56. Here I agree with Bagenstos, *supra* note 5, at 13–15. Quality-of-life judgments come nearest to justifiability in the rare cases where some patients (e.g., those in a persistent vegetative state) are unable to communicate about their quality of life, no matter what accommodations are offered. Relying on others’ judgments about their quality of life would not inappropriately ignore their “inside” perspective, because that perspective is inaccessible. *Cf.* Bagenstos, *supra* note 5 at 14 (contrasting “inside” and “outside” perspectives on disability); Alicia Ouellette, *Disability and the End of Life*, 85 OR. L. REV. 123, 174–75 (2006) (distinguishing persistent vegetative state from disability); Persad, *supra* note 12, at 297 (noting that comatose patients are unable to provide first-person testimony). But sufficiently high-quality “outside” judgments about these patients’ quality of life are likely impractical in a pandemic.
57. *E.g.*, *Cancer Facts & Figures 2019*, AM. CANCER SOC’Y (2019), <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf> [<https://perma.cc/P3CT-SPLP>] (discussing predicted life expectancy for cancer patients).
58. As the example of predictions grounded in verifiable outcomes indicates, subjective hunches need not play a role in life-expectancy predictions, nor are life-expectancy predictions proxies for quality-of-life judgments. *Contra* Letter from Disability Rights North Carolina to Roger Severino, Dir., Office for Civil Rights, U.S. Dep’t of Health & Human Servs., (May 5, 2020), <https://disabilityrightsncc.org/wp-content/uploads/2020/05/OCR-Complaint-5.5.20.pdf> [<https://perma.cc/BP4P-2FZR>].
59. *E.g.*, *Luwisch v. Am. Marine Corp.*, 956 F.3d 320, 329 (5th Cir. 2020) (observing that life expectancy is relevant to monetary awards for lost wages, as is “evidence that a particular person, by virtue of his health or occupation or other factors, is likely to live and work a longer, or shorter, period than the average” (quoting *DePerrodil v. Bozovic Marine, Inc.*, 842 F.3d 352, 361 (5th Cir. 2016))); *Conwed Corp. v. Union Carbide Corp.*, 443 F.3d 1032, 1043 (8th Cir. 2006) (“An award for impairment of earning capacity should be based on an evaluation of such factors as age, life expectancy, health . . .”).
60. *E.g.*, *Hoffer v. Inch*, 382 F. Supp. 3d 1288, 1311–12 (N.D. Fla. 2019) (reporting the use of eighteen-month life expectancy in state and federal guidelines for prisoner eligibility for Hepatitis C treatment).
61. 42 U.S.C. § 1395x(dd)(3)(A) (2018) (“An individual is considered to be ‘terminally ill’ if . . . the individual’s life expectancy is 6 months or less.”); *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1292–93 (11th Cir. 2019) (explaining the application of the “terminally ill” standard to hospice care eligibility). Some states condition access to physician-assisted dying on terminal illness. *E.g.*, COLO. REV. STAT. ANN. § 25-48-103 (West 2020).

of-life treatment preferences.⁶² Even those who question life-expectancy predictions are uncertain whether to categorically reject them, or instead to limit their use to short-term life expectancy.⁶³

Bagenstos argues that even if some disabilities genuinely limit life expectancy, it would be unfair to consider this when setting priorities.⁶⁴ As an ethical matter, I agree that using shorter-term life-expectancy predictions, as both lung allocation and model triage guidelines do,⁶⁵ is desirable because it captures the direct effects of conditions that limit short-term survival regardless of social arrangements, while striving to screen out the effects of social injustice on overall lifespan.⁶⁶ Short-term predictions also reduce concerns about uncertainty.

As a doctrinal matter, however, the law permits consideration of disabilities that limit lifespan, even when disability would not limit lifespan in a just world. As described in Section I.B.1, the law permits evidence-based medical judgments even when they disadvantage patients with certain disabilities. For instance, courts were legally justified to base their decisions on the risk HIV presented under prevailing social conditions,⁶⁷ even when doing so exacerbated the disadvantage or inconvenience people with HIV experienced and even though HIV would have been less deadly had society acted justly and pursued a cure earlier.

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62. CONN. GEN. STAT. ANN. § 38a-483c (West 2012) (permitting patients with a life expectancy of two years or less an expedited appeal from experimental treatment denial); NEV. REV. STAT. ANN. § 449A.551 (West 2019) (directing healthcare providers to explain the availability and features of a Provider Order for Life-Sustaining Treatment form to any patient with a “life expectancy of less than 5 years”).
63. Compare Bagenstos, *supra* note 5, at 9 n.30 (arguing that we should not use “quantity-of-life measures such as the number of expected life-years saved”), with *Who Gets Care*, TRADEOFFS (Apr. 14, 2020), <https://tradeoffs.org/2020/04/14/who-gets-care> [<https://perma.cc/ZG44-N264>] (reporting the statement of Bagenstos that “the safest standard is six months—the same time frame doctors use to determine hospice eligibility”). See also *Organ Transplant Discrimination*, *supra* note 17, at 43-44 (reporting the statement of bioethicist Joseph Stramondo that while transplant policy should not aim at unconstrained maximization of the number of life-years saved, a heart transplant “should go to the person who will live 5, 10, or 15 years with that heart and not the person who will only live 6 months”).
64. See Bagenstos, *supra* note 5, at 17 & n.67 (discussing the concern that short life expectancy reflects “societal discrimination”).
65. The model triage guidelines consider only short-term life expectancy. White et al., *supra* note 2, at 6. The lung transplantation guidelines similarly focus on one-year life expectancy. *A Guide to Calculating the Lung Allocation Score*, UNITED NETWORK FOR ORGAN SHARING 6 https://unos.org/wp-content/uploads/unos/lung_allocation_score.pdf [<https://perma.cc/EK93-56NG>].
66. See *Cancer Facts & Figures 2019*, *supra* note 57, at 21 (identifying cancers that sharply limit short-term survival); cf. Persad, *supra* note 12, at 302 (noting that many disadvantages people with disabilities face are attributable to social injustice).
67. See *Lesley v. Chie*, 250 F.3d 47, 58 (1st Cir. 2001); *Onishea v. Hopper*, 171 F.3d 1289, 1299 (11th Cir. 1999).

Similarly, serious limitations on long-term survival were judged to be an acceptable reason to deny access to a liver transplant.⁶⁸ Notably, the law also permits triage policies to consider patients' age.⁶⁹

II. WHY EVIDENCE-BASED TRIAGE IS ETHICAL

In this Part, I turn from doctrinal to ethical analysis of evidence-based triage. As a starting point, the aim of saving more lives is widely endorsed.⁷⁰ Notably, many ethicists who reject utilitarianism endorse saving more lives, on the basis that saving more lives comes closest to meaningfully fulfilling our duties to each person,⁷¹ and recognizes the paramount and equal significance of each life.⁷²

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68. *Barnett v. Kaiser Found. Health Plan, Inc.*, No. C-92-4908 SBA, 1993 WL 738364, at *7 (N.D. Cal. Feb. 5, 1993), *aff'd*, 32 F.3d 413 (9th Cir. 1994).
69. *Contra* Bagenstos, *supra* note 5, at 16 (suggesting that HHS rejected the use of age in triage policies). While the HHS Office of Civil Rights recently purported to reject treatment decisions resting on “judgments about a person’s relative ‘worth’ based on . . . age,” *Bulletin supra* note 11, HHS’s authority under the Age Discrimination Act of 1975 (Age Act) is far more limited than its authority under disability discrimination statutes. The Age Act permits the use of age-based criteria to achieve the normal operation or statutory objectives of any program, including both programs authorized by federal law and those authorized by state or local law, and does not apply to programs that provide “benefits or assistance to persons” based on age or define “criteria for participation in age-related terms.” 42 U.S.C. § 6103 (2018); *see also* 45 C.F.R. § 90.13, 90.14 (2020). The Age Act “differs somewhat from the other civil rights statutes in that” it “itself specifies certain categories of age discrimination which will be considered permissible.” *NAACP v. Wilmington Med. Ctr., Inc.*, 491 F. Supp. 290, 316 (D. Del. 1980), *aff’d sub nom. NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322 (3d Cir. 1981); *see* Benjamin Eidelson, Comment, *Kidney Allocation and the Limits of the Age Discrimination Act*, 122 YALE L.J. 1635, 1651 (2013) (observing that the Age Act permits kidney transplant policies that consider age, and explaining that the Age Act “incorporated capacious exceptions to its prohibition on discrimination”). *See generally* Govind Persad, *Evaluating the Legality of Age-Based Criteria in Health Care: From Nondiscrimination and Discretion to Distributive Justice*, 60 B.C. L. REV. 889 (2019) (describing the Age Act’s exceptions and identifying numerous healthcare policies that consider age).
70. *See* sources cited *supra* note 13; *cf. Onishea*, 171 F.3d at 1299 (rejecting “the absurd conclusion that Congress has decreed even a few painful deaths in service of the [Rehabilitation] Act’s noble goal”).
71. Tom Dougherty, *Rational Numbers: A Non-Consequentialist Explanation of Why You Should Save the Many and Not the Few*, 63 PHIL. Q. 413, 420 (2013); Nien-hê Hsieh, Alan Strudler & David Wasserman, *The Numbers Problem*, 34 PHIL. & PUB. AFF. 352 (2006).
72. T.M. SCANLON, *WHAT WE OWE TO EACH OTHER* 232–34 (1998); Frances P. Kamm, *Health and Equity*, in *SUMMARY MEASURES OF POPULATION HEALTH: CONCEPTS, ETHICS, MEASUREMENT AND APPLICATIONS* 685, 685–88 (Christopher J.L. Murray et al. eds., 2002); *see also* Joint Statement, *Moral Guidance on Prioritizing Care During a Pandemic*, PUB. DISCOURSE (Apr. 5, 2020), <https://www.thepublicdiscourse.com/2020/04/62001> [https://perma.cc/75YJ-ZBWC] [hereinafter *Moral Guidance*]. *Contra* John M. Taurek, *Should the Numbers Count?*, 6 PHIL. & PUB. AFF. 293 (1977).

While saving more years of life engenders more debate, some nonutilitarian ethicists also recognize it as appropriate.⁷³ Diverse participants in recent community engagement studies of triage policies similarly endorsed considering probability of survival and—though less strongly—years of life saved.⁷⁴ These arguments provide compelling ethical support for evidence-based triage, particularly when it emphasizes saving more lives and regards saving life-years as a subordinate and constrained aim.⁷⁵ Indeed, those willingly accepting social and economic burdens in order to save more lives might reasonably feel betrayed if triage policies abandoned that goal.

In this Part, I advance a more ambitious ethical argument: evidence-based triage not only saves more lives overall, but it likely saves more lives among patients with disabilities.⁷⁶ While this argument is not necessary for evidence-based triage to be ethical, it demonstrates its consonance with the goals of cross-disability advocacy, and helps dispel the mistaken framing of evidence-based triage as primarily burdening people with disabilities while primarily benefiting people without disabilities.

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73. See, e.g., Samuel J. Kerstein, *The Badness of Death for Us, the Worth in Us, and Priorities in Saving Lives*, in *SAVING PEOPLE FROM THE HARM OF DEATH* (Espen Gamlund & Carl Tollef Solberg eds., 2019); cf. *Moral Guidance*, *supra* note 72 (reporting that some of the document’s authors believe that saving more life-years is relevant, while others disagree).
74. Monica Schoch-Spana et al., *Influence of Community and Culture in the Ethical Allocation of Scarce Medical Resources in a Pandemic Situation: Deliberative Democracy Study*, 12 J. PARTICIPATORY MED. 7-8 (2020), <https://jopm.jmir.org/2020/1/e18272/pdf> [<https://perma.cc/BF2W-U5SG>] (finding that over seventy percent of Maryland focus group participants and eighty-five percent in a smaller Texas group regarded probability of survival as relevant, with fewer than ten percent rejecting it, and that fifty percent or more in both groups regarded years of life saved as relevant). These results echo findings in more abstract contexts. See, e.g., Mark Kelman & Tamar Admati Kreps, *Playing with Trolleys: Intuitions About the Permissibility of Aggregation*, 11 J. EMPIRICAL LEGAL STUD. 197, 205 (2014) (reporting that seventy-eight percent of respondents believed that a scarce medicine must be allocated to save ten patients rather than one, and that eighty-five percent believed allocating it to save ten was at least permissible).
75. Emanuel et al, *supra* note 1, at 4 (describing saving years of life as a “subordinate aim”); Mello, Persad, & White, *supra* note 6, at 4 (constraining the goal of saving years of life to short-term differences in life expectancy); cf. *Moral Guidance*, *supra* note 72.
76. For simplicity, I focus only on the goal of saving more lives. It is plausible that policies considering short-term life expectancy likewise save more years of life among people with disabilities, but the analysis is more complex.

A. *Evidence-Based Triage Benefits Many Patients with Disabilities*

How evidence-based triage affects a given patient or group depends on two factors: (1) whether they are likely to need scarce, potentially lifesaving treatments, and (2) whether they are likely to benefit from those treatments. These factors create three broad categories of patients:

1. Patients unlikely to need scarce, potentially lifesaving treatment, who will be largely unaffected by triage policies.
2. Patients who are more likely to need these treatments, but have comparatively good prospects of benefit. They will likely fare better under evidence-based triage, which makes more treatments available to patients who can benefit, than under random selection or minimal triage.
3. Patients who are more likely to need these treatments, yet have poor prospects of benefit even with them. They will likely fare worse under evidence-based triage than under random selection or minimal triage, although the difference may not be large given their limited prospects of benefit even with treatment.

Because evidence-based triage aims to save more lives, the gains for patients in the second group are expected to exceed the losses for patients in the third group. Imagine a stylized triage scenario where the second group comprises twenty patients with a fifty percent chance of survival and the third comprises twenty with a ten percent chance; only twenty treatments are available. Evidence-based triage prioritizes the second group, saving ten lives. In contrast, random selection, which treats the groups identically, saves five fewer lives in the second group and only one more in the third.

In this Section, I suggest that there is reason to believe that the second group of patients, those who need scarce treatments but can benefit from them, is likely to contain a greater proportion of people with disabilities than the first group. This, in combination with the fact that evidence-based triage aims at saving more lives, makes it plausible that the people with disabilities who would be saved only by evidence-based triage outnumber the people with disabilities in the third group who would fare better under random selection or minimal triage. The plausibility of this claim is not required for evidence-based triage to be legal or ethical: law and morality value all patients, not only those with disabilities. Nor is it sufficient for legality: a policy could illegally disadvantage patients with specific disabilities even if it is better for most patients with disabilities.⁷⁷ But it

77. Bagenstos, *supra* note 5, at 19 (arguing that antidiscrimination law “protect[s] individuals”); see also Hensel & Wolf, *supra* note 15, at 741-61 (collecting cases).

helps to support the consonance of evidence-based triage with a disability advocacy approach that centers the interests of patients with disabilities.

The predicted benefits of evidence-based triage for many patients with disabilities undermine the generalization that evidence-based triage disadvantages patients with disabilities.⁷⁸ They also challenge Bagenstos’s suggestion that triage policies that consider disabilities “place the burden of resource scarcity on disabled individuals” and his claim that “a process in which people with disabilities were equally represented vis-à-vis the nondisabled, and in which the interests of both groups were given equal concern” would exclude disability as a factor.⁷⁹ And they similarly challenge the claim that considering probability of survival or quantity of resources required would “significantly disadvantage people with disabilities.”⁸⁰ Disability advocacy has compelling reasons to endorse evidence-based triage policies that consider differences in patients’ prospect of benefit and the quantity of resources they need, because many of the additional lives saved by such policies will be the lives of patients with disabilities, since the overwhelming majority of disabilities do not affect these factors. Taking “equal account of the interests of disabled people”⁸¹ does not mean treating all people with disabilities the same – it means treating people differently when, and only when, this is justified by their differences.

Bagenstos questions whether we can “know that a policy explicitly denying treatment to some individuals based on their disabilities is going to benefit more people with disabilities overall.”⁸² There is uncertainty here, but we certainly cannot know that random selection or minimal triage will more effectively avoid “deny[ing] people with disabilities important benefits” or “forcing disabled individuals to face deadly consequences because of societal decisions not to invest in sufficient treatments.”⁸³ In fact, there are good reasons to believe that random selection and minimal triage present greater risk of generating these undesirable results. First, forcing hospitals to ignore evidence about prospect of benefit may

78. Ne’eman, *supra* note 5. This generalization parallels the broader fallacy that all disabilities are identical. Cf. *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 442 (1985) (observing that individuals with intellectual disabilities are not “all cut from the same pattern”); Ouellette, *supra* note 56, at 174 (discussing differences between disabilities).

79. Bagenstos, *supra* note 5, at 11, 13.

80. Hellman & Nicholson, *supra* note 5, at 25; *see also id.* (claiming that giving equal ventilator time to all patients would negatively affect those with “pre-existing health conditions”).

81. Bagenstos, *supra* note 5, at 13.

82. *Id.* at 19. Proposals for evidence-based triage do not categorically exclude individuals with disabilities, but instead use individualized determinations that consider whether a disability affects prospect of benefit. *See supra* Section I.A.

83. Bagenstos, *supra* note 5, at 10, 17.

not be the best way of allowing “people with disabilities an equal chance to survive,”⁸⁴ because disabilities likely also affect the need for scarce, lifesaving treatment, making the number of treatments available relevant. For instance, given the spread of COVID-19 in group housing,⁸⁵ patients with disabilities (such as sensory and intellectual disabilities) that do not limit their prospect of benefit are likely to be overrepresented among COVID-19 patients.⁸⁶ They therefore have much to lose from a policy that makes fewer treatments available to patients who can benefit, since such a policy not only leads to more deaths but concentrates those deaths among those likelier to contract COVID-19.⁸⁷

Second, evidence-based triage could benefit patients with disabilities even under the implausible assumption that disabilities only limit prospect of benefit and do not increase the risk of contracting COVID-19. Assume, for instance, that only five of the twenty COVID-19 patients with a greater prospect of benefit in the example discussed above have disabilities, whereas all twenty patients with a lesser prospect of benefit do.⁸⁸ Even under these assumptions, evidence-based

84. Hellman & Nicholson, *supra* note 5, at 25.

85. See, e.g., Jason Moon, *More Than Three in Four N.H. COVID Deaths Occurred in Long-Term Care Homes*, N.H. PUB. RADIO (May 5, 2020), <https://www.nhpr.org/post/more-three-four-nh-covid-deaths-occurred-long-term-care-homes#stream> [<https://perma.cc/UF53-A3EN>].

86. For instance, almost fifty percent of people over age seventy-five have hearing impairments, and more than forty percent have cognitive impairment or dementia. See Nat’l Institute on Aging, *Hearing Loss: A Common Problem for Older Adults*, NAT’L INST. HEALTH (Nov. 20, 2018), <https://www.nia.nih.gov/health/hearing-loss-common-problem-older-adults> [<https://perma.cc/778P-YG8D>]; Kenneth M. Langa et al., *A Comparison of the Prevalence of Dementia in the United States in 2000 and 2012*, 177 JAMA INTERNAL MED. 51, 55 (2017). More than sixty percent of nursing home residents are over seventy-five. *Long-Term Care Providers and Service Users in the United States, 2015-2016*, NAT’L CTR. FOR HEALTH STATS. 20 (Feb. 2019), https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf [<https://perma.cc/RVH7-Z27F>]. These patients benefit in two ways from policies that save more lives: directly from greater access to scarce treatments for themselves, and indirectly from greater access for caregivers and loved ones.

87. Cf. Ne’eman, *supra* note 5 (conceding that “[i]f someone needs twice the average amount of time on a ventilator, maintaining that we shouldn’t turn them away . . . means that we are potentially costing the lives of two people who come into the [intensive care unit] after them,” but nevertheless endorsing a policy that saves fewer lives). Ne’eman does not address the possibility that the lives lost will be those of patients with disabilities.

88. Cf. *Disability Impacts All of Us*, CTR. FOR DISEASE CONTROL, <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html> [<https://perma.cc/8LTA-UGNJ>] (reporting that over a quarter “of adults in the United States ha[s] some type of disability”). In reality, patients with preexisting disabilities may be more likely to contract COVID-19, and many patients who are unlikely to benefit will not have preexisting disabilities.

triage would be expected to save more people with disabilities.⁸⁹ A greater but unequal chance of survival seems ethically preferable to a smaller but more equal chance.⁹⁰

Last, doubts that an evidence-based triage policy will in fact save more patients with disabilities would not end the analysis. As noted above, evidence that evidence-based triage will benefit *many* patients with disabilities importantly counters narratives that cast evidence-based triage as benefiting only patients without disabilities while burdening all patients with disabilities. Further, if desired, an evidence-based triage policy could be made more favorable to patients with disabilities by adding allocation criteria, rather than subtracting allocation criteria by retreating to random selection or minimal triage. For instance, patients with disabilities who can benefit, or patients who are disadvantaged more broadly, could be explicitly prioritized.⁹¹ Such an approach could still aim to save more lives, while trying intentionally to ensure that people with disabilities comprise a fair number of those saved. Meanwhile, though it is important to aim for accuracy in evidentiary determinations, randomness is not the solution to inaccuracy. Just as the problem of bias in medical care justifies anti-bias efforts rather than abandoning the potentially lifesaving enterprise of diagnosis and treatment in favor of minimal or random approaches, the same is true regarding concerns about bias in allocation.⁹²

The more challenging question is when, if ever, we should accept saving fewer lives overall in order to benefit patients with specific disabilities. While disability policy sometimes allows for accommodations that present few trade-offs between potential beneficiaries,⁹³ such options are unlikely to be available

89. Evidence-based triage would be expected to save ten patients: 2.5 with disabilities and 7.5 without. Random selection would be expected to save only six: 2.25 with disabilities (1.25 from the group with good prospects of benefit and 1 from the group with poorer prospects of benefit) and 3.75 without.

90. Cf. JOHN RAWLS, *A THEORY OF JUSTICE* 131 (rev. ed. 1999) (permitting “inequalities” that “improve everyone’s situation, including that of the least advantaged”).

91. Cf. Douglas B. White et al., *Model Hospital Policy for Fair Allocation of Scarce Medications to Treat COVID-19*, U. PITT. 1 (May 28, 2020), <https://ccm.pitt.edu/sites/default/files/2020-05-28b%20Model%20hospital%20policy%20for%20allocating%20scarce%20COVID%20meds.pdf> [<https://perma.cc/BY3T-YJKL>] (proposing to consider patients’ residence in a disadvantaged community as an allocation factor); Parag A. Pathak et al., *Leaving No Ethical Value Behind: Triage Protocol Design for Pandemic* 12 (Nat’l Bureau of Econ. Research, Working Paper No. 26951, 2020), <https://www.nber.org/papers/w26951> [<https://perma.cc/V88B-G44X>] (suggesting the use of reserve categories to prioritize disabled or disadvantaged patients).

92. Cf. *supra* note 41 and related text. *Contra* Bagenstos, *supra* note 5, at 20 (arguing that concerns about bias “should lead to great skepticism about the quality of the ‘evidence’”).

93. E.g., Adam M. Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251, 1298 (2007) (“Curb cuts are an example: at least for new construction, they cost little in the

where scarce medical resources are concerned. In the face of scarcity, allocating scarce resources—even resources that are scarce because of social policy determinations—requires a normative framework.⁹⁴ A triage policy that is worse for individuals with specific disabilities cannot be dismissed as unjust discrimination on that basis, but must be analyzed against a broader backdrop of normative analysis that considers the claims of different individuals and social groups.⁹⁵ Saving more lives overall is a compelling starting point. By aiming to save more lives, evidence-based triage aligns with widely adopted measures like physical distancing and postponement of medical procedures; it aims to save more patients, including many patients with disabilities, even if this works to the disadvantage of patients with certain disabilities.

B. Evidence-Based Triage Protects Non-Visible Victims

In this Section, I challenge the claim that random selection serves the interests of politically marginalized people, including marginalized people with disabilities.⁹⁶ While Bagenstos is right to demand that “decisions that deny people with disabilities important benefits”⁹⁷ be democratically legitimate, the tragedy of scarcity is that *every* decision denies some people with disabilities important benefits. Patients whose disabilities substantially reduce their prospect of benefit can organize to offer personal narratives in opposition to evidence-based triage,⁹⁸ but allocation approaches that advantage those patients may poorly serve the interests of patients with other disabilities. In contrast, the patients with and without disabilities who fare worse under random selection are unaware of their fate until the decision has been made and have no unified narrative to offer policymakers. Advocacy should not mandate solidarity between people whose disabilities do not limit their prospect of benefit and those whose disabilities do

short run and they benefit wheelchair users, stroller pushers, and skateboard riders over the long run.”).

94. *Id.* at 1253 (observing that “deciding how to respond to ‘disability’ depends on a normative framework . . . [that] might be libertarian, utilitarian, egalitarian, some combination thereof, or something else,” and that “[t]here is no way to set priorities, make unavoidable tradeoffs, or confront cost issues without a normative orientation”).

95. *Cf. id.* at 1308 (noting that while disability rights advocacy grows out of a social movement perspective, “at some point . . . disability rights proponents might choose to confront more effectively the problems of limited resources and competing claims of justice,” and arguing that “devotion to elevating the status of a single interest group is not conducive to that task”).

96. Bagenstos, *supra* note 5, at 10–11 (arguing that the political marginalization of people with disabilities supports random selection).

97. *Id.* at 10.

98. See, e.g., Washington Complaint, *supra* note 5.

limit their prospect of benefit.⁹⁹ Rather, each patient, whatever their specific disability, should be considered as an individual.

Recognizing the multiple identities of patients with and without disabilities challenges the view that democratic legitimacy favors minimal triage or random selection,¹⁰⁰ as well as the related view that minimal triage or random selection best recognizes the equality of people with disabilities. While the passage of the disability discrimination laws did not categorically exclude the nondisabled, it likely *did* exclude or limit the participation of disadvantaged people with and without disabilities. We should worry that elite decisionmakers might be attracted to formally equal approaches – like random or first-come, first-served allocation – that save fewer lives and thereby likely increase deaths among disadvantaged people with and without disabilities, but that impose few or no burdens on better-off people who are less likely to need scarce, lifesaving treatments and are likelier to reach the hospital first if they do. Significantly, the community engagement research discussed earlier reveals broad rejection of both lottery and first-come, first-served allocation, and underscores concerns that the latter approach favors the better-off.¹⁰¹

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99. Govind Persad & David Wasserman, *Diversity and Solidarity in Response to Covid-19*, HASTINGS CTR. (May 13, 2020), <https://www.thehastingscenter.org/diversity-and-solidarity-in-response-to-covid-19> [<https://perma.cc/Z4BE-72GM>] (“We should not force the person whose disability doesn’t limit their prospect of benefit to be treated like others whose disabilities do limit their prospect of benefit, simply because both patients share the common ascribed identity of having a disability.”). *Contra* Ari Ne’eman, *When It Comes to Rationing, Disability Rights Law Prohibits More than Prejudice*, HASTINGS CTR. (Apr. 10, 2020), <https://www.thehastingscenter.org/when-it-comes-to-rationing-disability-rights-law-prohibits-more-than-prejudice> [<https://perma.cc/8DWK-UPEJ>] (arguing that the use of triage principles that aim to save more lives but disadvantage patients with certain disabilities “is inconsistent with the principle of solidarity at the core of the disability rights movement”).
100. Bagenstos, *supra* note 5, at 10-11 (arguing that “the political process that led to the enactment of the disability discrimination laws did not exclude the *nondisabled*,” and that “[w]hen a group passes a law to put burdens on itself, there is little reason to worry that it is failing to take account of the full array of costs”). My concern about this claim is twofold: interpreting the disability discrimination laws to preclude evidence-based triage does not only burden people without disabilities, and interpreting them in this way may inequitably burden disadvantaged people, both with and without disabilities, who were excluded from discussions around the passage of those laws. *Cf.* SAMUEL R. BAGENSTOS, *LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT* 3-4 (2009) (recognizing that people with different disabilities often have disparate interests).
101. See Schoch-Spana et al., *supra* note 74, at 7; see also *Organ Transplant Discrimination*, *supra* note 17, at 44 (discussing potential unfairness of first-come, first-served transplant allocation to people with disabilities); Univ. of Colo. Ctr. for Bioethics and Humanities, *Crisis Triage and People with Disabilities: Historical Lessons for a Time of COVID*, YOUTUBE (Apr. 24, 2020), <https://www.youtube.com/watch?v=o1wxhQndikI&feature=youtu.be&t=1531> (statement of

Ultimately, rather than assisting those “most likely to have been excluded”¹⁰² from policymaking, random selection and minimal triage would increase risk for many disadvantaged people and people with disabilities, while protecting the interests of a small group that is better positioned to organize.¹⁰³ Cross-disability advocacy should acknowledge, not downplay, this problem. While Bagenstos recognizes potential tradeoffs when he suggests that “[m]aybe denying lifesaving treatment to individuals with cystic fibrosis could save more individuals who take daily medication for high blood pressure,”¹⁰⁴ this example goes astray in two ways. First, evidence-based triage involves individualized determinations, not categorical denial of treatment to all cystic fibrosis patients. Second, Bagenstos compares cystic fibrosis to high blood pressure, a common condition many would regard as less significant than cystic fibrosis. Here is a better example: in scarcity, denying lifesaving treatment to those patients whose cystic fibrosis *makes them comparatively unlikely to benefit* could save more patients with cystic fibrosis *who are nevertheless likely to benefit*. This outcome is achievable under evidence-based triage, which considers individualized evidence about benefit, but is foreclosed both by minimal triage—which mandates ignoring the difference between the possibility of benefit and its likelihood—and by random selection.

C. *The Social Origins of Scarcity Cannot Justify Sacrificing Lives*

Bagenstos and others rightly observe that scarcity stems not just from COVID-19, but from social and political decisions to underinvest in testing and equipment.¹⁰⁵ But the social origins of scarcity do not support random selection or minimal triage.¹⁰⁶ Some suggest that adopting these approaches would encourage decisionmakers to more vigorously prevent initial scarcity.¹⁰⁷ This as-

Julie Reiskin, Executive Dir. of Colorado Cross-Disability Coalition) (describing her organization’s rejection of first-come, first-served allocation). These findings complicate the claim that “many people believe” lottery allocation “would be fairer.” Bagenstos, *supra* note 5, at 21.

102. Bagenstos, *supra* note 5, at 11.

103. Cf. Deborah A. Small, *On the Psychology of the Identifiable Victim Effect*, in IDENTIFIED VERSUS STATISTICAL LIVES: AN INTERDISCIPLINARY PERSPECTIVE 13-23 (I. Glenn Cohen et al. eds., 2015) (describing psychological biases that favor visible, identifiable individuals over disadvantaged groups).

104. Bagenstos, *supra* note 5, at 19.

105. *Id.* at 13.

106. Cf. Samaha, *supra* note 93, at 1253 (observing that the causal origins of disadvantage are separable from policy prescriptions to address disadvantage).

107. David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 73 (1996) (supporting random selection in part because if “decisionmakers realize that they cannot fully control the outcome of rationing

sumption lacks evidentiary support. And it becomes implausible when opposition to triage policies involves inviting the same federal officials who inadequately managed the initial COVID-19 response¹⁰⁸ to now control how others respond to the scarcity they produced.¹⁰⁹

Concentrating power in the hands of those responsible for scarcity will likely undermine, not increase, incentives to prevent scarcity. Disability advocates and others would therefore be wise to reject, for instance, recent proposals to allow the federal government to deny ventilators from the Strategic National Stockpile to any state that the Secretaries of HHS and of Homeland Security judge to be allocating ventilators in a discriminatory fashion.¹¹⁰ Such an approach would afford federal administrators largely unguided power to deny states ventilators, a particularly unwise decision given existing concerns about politicized and otherwise unjustified federal allocation of scarce COVID-19 treatments.¹¹¹ It would also be inconsistent with HHS's recognition that state decisionmakers "have the greatest insight into community-level needs in the COVID-19 response."¹¹² And, even if it accurately identified discrimination, this approach would impose double jeopardy on residents of states with discriminatory policies by denying them access to ventilators. A preferable approach, which would avoid undesirable "federal superintendence of treatment decisions traditionally entrusted to state governance,"¹¹³ would permit states and localities to adopt triage policies that

decisions and that therefore treatments they might need when they become patients might be denied, they might be more generous in allocating resources for health care coverage").

108. See, e.g., Terry Gross, *Reporter: White House Knew of Coronavirus' 'Major Threat,' but Response Fell Short*, NPR (Mar. 12, 2020, 1:20 PM ET), <https://www.npr.org/2020/03/12/814881355/white-house-knew-coronavirus-would-be-a-major-threat-but-response-fell-short> [<https://perma.cc/N425-3XUK>].
109. See Washington Complaint, *supra* note 5, at 4 (calling on the HHS Office of Civil Rights "to act swiftly to clearly and firmly articulate the violation of civil rights" caused by Washington's triage plan).
110. STAFF OF S. COMM. ON HEALTH, EDUC., LABOR, AND PENSIONS, 116TH CONG. DISCUSSION DRAFT OF EQUAL CARE ACT, at 2 (2020) https://www.sasse.senate.gov/public/_cache/files/3a8bb77f-d4ad-4ab5-a81a-6f1a6b0cc6fd/bon20137.pdf [<https://perma.cc/7224-DTLS>].
111. Jonathan Allen, Phil McCausland & Cyrus Farivar, *Want a Mask Contract or Some Ventilators? A White House Connection Helps*, NBCNEWS (Apr. 24, 2020, 5:01 AM EDT), <https://www.nbcnews.com/politics/white-house/political-influence-skews-trump-s-coronavirus-response-n1191236> [<https://perma.cc/Y634-GTUE>]; Lev Facher, *Trump Administration Announces Plan to Distribute Covid-19 Drug amid Concerns over Allocation*, STAT (May 9, 2020), <https://www.statnews.com/2020/05/09/trump-administration-announces-plan-to-distribute-covid-19-drug-amid-concerns-over-allocation> [<https://perma.cc/2CYD-WZXZ>].
112. Facher, *supra* note 111.
113. *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 643 (1986) (plurality opinion); see also *Lesley v. Chic*, 250 F.3d 47, 54 (1st Cir. 2001) (similar).

mitigate harms resulting from federally exacerbated shortages, while allowing courts to use the established tools of disability law to address any concerns that these policies unfairly discriminate on the basis of disability.

CONCLUSION

I have argued that random selection and minimal triage are not required by law, and would be worse than evidence-based triage for patients with and without disabilities. Instead of advocating for federal intervention to impose these approaches, disability advocates would do better to support the adoption of evidence-based state triage guidelines that are responsive to public input, and to ensure that these guidelines are free of biased or unsupported assumptions about disabled patients.¹¹⁴ They could also effectively marshal disability law in support of efforts to reduce scarcity and limit the spread of illness to vulnerable patients.¹¹⁵ Developing evidence-based triage guidelines, while working to reduce scarcity, is the most effective way to save people with and without disabilities from COVID-19.

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114. See, e.g., Meredith Cohn, *Who Gets a Ventilator when There's a Crush of Coronavirus Patients? Maryland Is Coming Up with a Plan*, *BALT. SUN* (Mar. 28, 2020, 3:34 PM), <https://www.baltimoresun.com/coronavirus/bs-hs-ventilator-surge-plan-20200327-dnguwrrf7vcr3sg45negc3na-story.html> [<https://perma.cc/8ZUJ-NFJJ>]; Elise Young & David Voreacos, *N.J. Starts Thinking Over How to Ration Scarce Ventilators*, *BLOOMBERG NEWS* (Mar. 26, 2020, 7:23 PM EDT), <https://www.bloomberg.com/news/articles/2020-03-26/n-j-forms-ethics-panel-to-guide-decisions-on-scarce-ventilators> [<https://perma.cc/VF88-6P7V>].
115. E.g., First Amended Class Action Complaint & Petition for Writ of Habeas Corpus, *Costa v. Bazron*, No. 1-19-cv-3185 (RDM) (D.D.C. Apr. 16, 2020) (alleging that the COVID-19 response at a psychiatric hospital violates the ADA).