MEMORANDUM

DATE:  April 3, 2020
RE:    Federal Law on Rationing Medical Care on the Bases of Disability and Age

Questions Presented: In follow-up to the memorandum published on March 31, 2020, available here, please answer the following six questions:

1) In rationing care, can the question of the survivability of the immediate treatment itself be taken into account? In that context, can co-morbidities, advanced age, or disability be taken into account?
2) Can general life expectancy be taken into account in rationing care?
3) In rationing care, can a child be given a preference over a 90 year old?
4) To what extent can the amount of resources required to treat a particular person be taken into account?
5) Can there be any reallocation of resources once the treatment has begun, i.e., removal of ventilators from one person to another?
6) In rationing care, can the status of the patient as a first responder be taken into account?

Short Answer: (1) Yes, (2) No, (3) Yes, (4) Generally to a significant extent, (5) Likely no, (6) Only if actually effective in defeating the pandemic.

LEGAL ANALYSIS

The novel coronavirus disease COVID-19 is causing shortages in healthcare resources, especially ventilators. According to recent reports, the hospitals in areas hit hardest by the pandemic are running out of ventilators, which are critical in treating severe respiratory cases. Consequently, healthcare providers may have to allocate resources based on individualized patient assessments.

As discussed in our previous memorandum, rationing medical supplies during triage forces providers into making difficult ethical and legal choices about who receives care and who does not. These life-or-death choices implicate serious legal concerns, particularly if providers allocate scarce resources to exclude elderly and disabled patients.
Several states have adopted ethical and legal standards for allocating medical supplies during a pandemic. For example, the New York Department of Health, in collaboration with the New York State Task Force on Life & the Law, issued Ventilator Allocation Guidelines that provide an ethical, clinical, and legal framework to assist health care providers and the public in the event of a severe influenza pandemic. Members of the task force included medical professionals representing the Archdiocese of New York and religious scholars. According to the task force, the NY Guidelines “are grounded in a solid ethical and legal foundation and balance the goal of saving the most lives with important societal values, such as protecting vulnerable populations, to build support from both the general public and health care staff.”

After extensive research and analysis, we conclude that the New York ventilator guidelines are a model framework to address the issues presented in this memorandum. We also conclude the guidelines are an appropriate example by which other government entities and healthcare providers can follow or model in creating their own crisis allocation protocols.

Legal answers to the six specific questions follow.

1. **Survivability can be taken into account, but only with respect to the immediate treatment.**

The goal of the age and disability anti-discrimination laws is to ensure equal opportunities to elderly persons and persons with disabilities to remedy historic discrimination and prejudice against them. Thus, if the anti-discrimination “laws mean anything, they mean that a treatment that is provided to someone who will not be disabled after treatment cannot be denied to someone [on the basis that they] will be disabled,” either as a result of the treatment, or in spite of the treatment. The same reasoning applies to age discrimination: medical treatment is not intended to change age, and so the fact that someone will still be elderly is irrelevant. But “[t]o the extent that this evaluation [of effectiveness] is limited to the most basic question of whether a particular patient will survive or receive a physiological benefit from implementation of the scarce resource, using medical effectiveness or benefit as allocation principles would seem consistent with the” anti-discrimination statutes. Through analogy to other legal regimes, most legal scholars (even disability advocates) seem to agree that care could be rationed based on lower likelihood of survivability, at least legally, if not morally. In this context, the Supreme Court has stated that a

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2. Id. at Preface.
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facially neutral regime need not provide greater care to individuals with greater need. Rather, the
care must simply “provide meaningful access” to the care available. But it appears unlikely based
on the High Court’s reasoning that a facially neutral regime which in effect excluded all individuals
with disabilities of above a certain age would satisfy the “meaningful access” paradigm.

Looking to the NY Guidelines, they provide that the primary goal of allocation protocols during a
severe influenza pandemic is “to save the most lives.” Thus, healthcare providers should
prioritize coronavirus patients who need ventilators to survive. Providers evaluate a patient’s
“survival” by “examining a patient’s short-term likelihood of surviving the acute medical episode
and not by focusing on whether the patient may survive a given illness or disease in the longterm
(e.g., years after the pandemic).” According to the NY Guidelines, this standard maximizes the
rate of survival:

Patients with the highest probability of mortality without medical
intervention, along with patients with the smallest probability of mortality
with medical intervention, have the lowest level of access to ventilator
therapy. Thus, patients who are most likely to survive without the
ventilator, together with patients who will most likely survive with
ventilator therapy, increase the overall number of survivors.

In short, prioritizing patients whose survival from the disease depends on ventilator therapy is an
objective evaluation that does not consider a patient’s age or disability. Although this assessment
requires individualized physician clinical judgment, it reduces the possibility that the provider may
make a biased decision based on a discriminatory classification.

2. Life expectancy cannot be considered in rationing care.

Because healthcare providers should prioritize the necessity of a ventilator for a coronavirus
patient’s survival, physicians should not base an allocation decision on that patient’s post-
treatment life expectancy. This question was answered comprehensively in our March 31, 2020,
memorandum, available here. In sum, “[t]he likelihood that a patient will function at a lower level
of ability after treatment [i.e., retain a disability or have fewer years left] should be irrelevant to any
measure of the treatment’s effectiveness if the treatment does not itself cause the loss of ability
and is not intended to restore that ability.”

(discussing heart transplant protocols); Hensel & Wolf, supra, at 758 (discussing EEOC guidance).


Id.; see also 45 C.F.R. § 84.4(b)(2).

NY Guidelines, at 4.

Id.

Id.

Timothy B. Flanagan, ADA Analyses of the Oregon Health Care Plan, 9 ISSUES L. & MED. 397, 404 (1994) (quoting
Letter from Thomas J. Marzen, General Counsel, and Daniel Avila, Staff Counsel, National Legal Center for the
A difficult consideration, however, is for patients who have a short life expectancy regardless of their acute COVID-19 disease. For example, a patient may have a cancer prognosis that only gives him a few months to live. If he contracts COVID-19, should he be assigned scarce medical resources such as a ventilator? Apparently from a moral perspective, many protocols, including the NY Guidelines, provide that it may be a permissible triage decision to refer that patient to “alternative forms of medical intervention and/or palliative care." Doing so, the task force concludes, would prioritize coronavirus patients who need ventilator therapy to survive.

From a legal perspective, however, at least two scholars have noted that because “there is no clear line-drawing in such models between the short- and long-term" age discrimination is potentially at issue. Further, according to those scholars, under the 2008 amendments to the Americans with Disabilities Act, individuals with terminal illnesses would likely qualify as disabled, making the withholding of care based on poor short-term prognosis invalid. Without clear legal authority supporting these positions, however, we believe the NY Guidelines remain more appropriate.

3. Preferences can be given to children, but only in narrow circumstances.

It is general public policy to prioritize the protection of children. Further, although age qua age should not be a determining characteristic in rationing care, we believe that using status as a minor in a tie-breaking situation is probably permissible due to the traditional public policy of protecting minors.

As a general matter, we agree with the NY Guidelines: “[V]entilators should be allocated in a manner to maximize the number of survivors, and young age should not be a primary triage factor. Instead, clinical criteria should be used to give patients who were deemed most likely to survive with ventilator therapy an opportunity for treatment." As we noted in our previous memorandum, any discrimination on the basis of age by federally funded healthcare providers implicates several civil rights statutes, including the Age Discrimination Act of 1975.

The NY Guidelines did recommend, however, that “young age may be considered as a tie-breaking criterion in limited circumstances." The Task Force determined that providers may use young age as a tie-breaker in allocating ventilators only after “all available clinical factors have been

Medically Dependent & Disabled, Inc. to the Hon. Christopher H. Smith, United States Representative (Dec. 5, 1993)).

12 NY Guidelines, at 14; see also Hensel & Wolf, supra, at 760 & n.236 (discussing another proposed protocol).

14 Hensel & Wolf, supra, at 760.

15 Id.


17 Cf. Cal. Welf. & Inst. Code § 3020(a) (“The Legislature finds and declares that it is the public policy of this state to ensure that the health, safety, and welfare of children shall be the court’s primary concern in determining the best interests of children when making any orders regarding the physical or legal custody or visitation of children.”)

18 NY Guidelines, at 83.

19 Id. at 84.
examined and the likelihood of survival among the pool of eligible patients has been found equivalent.\textsuperscript{20} That tie-breaking determination “acknowledge[s] general societal values and advance[s] the goal of saving the most lives.”\textsuperscript{21}

Children could be given a preference over a ninety-year old when there are not enough supplies—such as ventilators—to serve all equally prioritized people—that is, people at the same risk and likelihood of benefit. The Minnesota Pandemic Project on Resource Allocation concluded that taking into consideration significant differences in age—for example, nine versus ninety years of age—could be more fair than randomizing among people. The panel agreed that limited, particular attention to age within a single tier, in the extreme circumstances of a severe pandemic, need not be perceived as wrongful age discrimination.\textsuperscript{22} Moreover, according to the Utah’s Crisis Standards of Care Guidelines, people of ninety years old and over may be considered for exclusion from admission or transfer to critical care.\textsuperscript{23}

4. To what extent can the amount of resources required to treat a particular person be taken into account.

This question is best answered under the same analysis as the first question, discussed above. Based on the High Court’s reasoning,\textsuperscript{24} federal regulations now provide that “aids, benefits, and services . . . are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement.”\textsuperscript{25} Thus, most likely, the amount of resources required to treat someone may only be taken into account so long as the threshold does not meaningfully exclude all individuals with disabilities or above a certain age. And, different standards as to how much resources may be devoted should be developed for individuals with, and without, disabilities.

5. Can there be any reallocation of resources once the treatment has begun, i.e., removal of ventilators from one person to another.

Our focus has been specifically on whether the federal anti-discrimination statutes address rationing of healthcare during a time of crisis, and we do not believe these statutes provide the rule of decision with respect to this question. Rather, an appeal to constitutional or common law on the right to direct own’s own medical care, proximate causation, and duty appears necessary. Importantly, this issue is of pressing concern because in practice many physicians do actually

\textsuperscript{20} Id.\textsuperscript{21} Id. Notably, this same reasoning applies to “parents with small children.” Email from Anderson to LiMandri, ¶3.\textsuperscript{22} Dorothy E. Vawter, et al., For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic, Minnesota Center for Health Care Ethics, 60 (2010), \url{https://www.health.state.mn.us/communities/ep/surge/crisis/ethics.pdf}.\textsuperscript{23} Utah Crisis Standards of Care, 31 (June, 2018) \url{https://coronavirus.utah.gov/wpcontent/uploads/Final_Utah_Crisis_Standards_of_Care_011719-I.pdf}.\textsuperscript{24} Choate, 469 U.S. at 302–04.\textsuperscript{25} 45 C.F.R. § 84.4(b)(2) (italics added).
provide or withhold care in contravention of the patient’s wishes.\textsuperscript{26} Unfortunately, “[t]here appears to be no clear legal precedent on the subject of whether a patient has the right to receive treatment he or she demands.”\textsuperscript{27}

As a general matter, the constitutional right to determine and direct one’s own medical treatment is clearly established.\textsuperscript{28} These cases, however, primarily deal with the right to refuse medical treatment, not the right to demand it, and so are analytically of little help.\textsuperscript{29} In some instances, the courts analyze the nonconsensual (or objected to) withdrawal of life support—objected to by a third party—but then resolve the issue based on futility. In those cases, there has generally been recognized the absence of a duty on the part of a physician to provide treatment where doing so would be futile.\textsuperscript{30} Outside the context of futility, and in specifically addressing the issue of a pandemic, one scholar has noted that “[t]hus far, no governmental interest has ever been found sufficiently compelling to infringe on the life of a conscious and protesting law-abiding citizen, who might recover if given treatment.”\textsuperscript{31} Futility, however, is a fluid concept, and so there are cases dealing with the nonconsensual withdrawal of life-sustaining treatment where futility was debated.\textsuperscript{32}

Even with respect to these cases, the law is inconsistent across states. For example, in California, case law provides that under the common law, the standard of care may be to withdraw life support, and in that context, even if care is withdrawn over the wishes of the patient, doing so is not likely criminal: “As a predicate to our analysis of whether the petitioners’ conduct amounted to an ‘unlawful killing,’ we conclude that the cessation of ‘heroic’ life support measures is not an affirmative act but rather a withdrawal or omission of further treatment.”\textsuperscript{33} And in Massachusetts, a jury found a hospital not liable when it withdrew care over the wishes of the patient because doing so was consistent with the hospital’s interpretation of the standard of care.\textsuperscript{34} The surprising California dicta, however, has not been followed in several other states, and “[u]nilateral decisions

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\textsuperscript{26} D.A. Asch, et al., \textit{Decisions to limit or continue life-sustaining treatment by critical care physicians in the United States: conflicts between physicians’ practices and patients’ wishes}, AM. J. RESPIR. CRIT. CARE. MED. 1511995288292 (Feb. 1995).
\textsuperscript{27} J. Andrew Billings, MD, et al., \textit{The Culture Change of Life and Death: Will Health Reform, Demographics and the Economy Bring It About?}, 20110627 AHLA-SEM 17 (2011).
\textsuperscript{29} Id. Notably, the only constitutional case regarding the right to demand treatment that appears to exist concerned the due process right to control the upbringing of one’s children. In that context, one court has held that a parent has the constitutional right to demand treatment. \textit{Matter of Baby K}, 832 F. Supp. 1022, 1030 (E.D. Va. 1993).
\textsuperscript{33} Barber, 147 Cal. App. 3d at 1016. Without question, this holding does not square with traditional moral systems, including Catholic moral theology. Email from Charles C. Camosy, Ph.D., Associate Professor of Bioethics at Fordham University, to Charles S. LiMandri, Esq., Partner, LiMandri & Jonna LLP, ¶ 4 (Apr. 2, 2020).
\textsuperscript{34} Moore, \textit{supra}, at 450–451.
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to stop [life sustaining medical treatment] have thus led to homicide charges and at least one conviction” in Virginia, Kansas, and Wisconsin.\textsuperscript{35}

The California case, also, was decided prior to the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA).\textsuperscript{36} In interpreting it, the Fourth Circuit acknowledged that the standard of care may be to not provide, or withdraw, life sustaining treatment, but that doing so may violate the EMTALA, under which “the Hospital must provide that treatment necessary to prevent the material deterioration of each patient’s emergency medical condition.”\textsuperscript{37}

In sum, it appears that physicians could contend that withdrawing a ventilator based on reasoning other than futility would be within the standard of care during a pandemic. Nevertheless, doing so could be viewed as a violation of the EMTALA—absent statutory protections. Such protections, however, do exist: namely the Public Readiness and Emergency Preparedness Act, which provides immunity from tort claims during a public health emergency.\textsuperscript{38} Turning to criminal or constitutional law, there is insufficient case law to provide a rule, although it seems likely that under both regimes, courts could find that any otherwise available rights under those areas of law are unavailable under these circumstances.

Finally, turning to moral or natural law, “there are strong prudential reasons against taking away a resource against the wishes of a patient—especially for confidence in the healthcare system and doctor-patient relationship—but it’s a defeasible prudential concern.”\textsuperscript{39} “[T]he moral truth of the matter is that scarce healthcare resources can be reallocated or redistributed in case of extreme need,” “even if a patient does not consent.”\textsuperscript{40} This “prudential” concern, however, is likely heightened for disabled individuals, many of whom are afraid that their privately owned ventilators will be taken from them, and reallocated to others, should they go to a hospital.\textsuperscript{41}

6. In rationing care, can the status of the patient as a first responder be taken into account.

We do not believe that the age or disability anti-discrimination statutes apply to this question, and we are unaware of any law precluding the prioritization of first responders. However, prior CDC ethical guidelines have provided, that “to justify a restrictive public health measure, there must be


\textsuperscript{36} 42 U.S.C. § 1395dd.

\textsuperscript{37} \textit{Matter of Baby K} , 16 F.3d 590, 596 (4th Cir. 1994).


\textsuperscript{39} Email from Anderson to LiMandri, ¶ 4.

\textsuperscript{40} \textit{Id.}; \textit{see also} Email from Camosy to LiMandri, ¶ 3 (same).

\textsuperscript{41} Telephone Call from Matt Vallière, Executive Director, Patients Rights Action Fund, to Jeffrey M. Trissell, Esq., Attorney-at-Law, LiMandri & Jonna LLP (Apr. 1, 2020).
good evidence that the measure is necessary and will be effective.” Therefore, the analysis should likely turn on whether the treated first responders will be able to “recover in time to re-enter the work force and achieve their instrumental purposes during the pandemic wave.”

**CONCLUSION**

“In general, . . . the only proper way to think about any of [these] questions on the moral level is to think about the common good that we are seeking, and all the various components of that common good, and how principles of justice apply in pursuing that good. This’ll help explain why we can prioritize the care of first responders, children, parents with small children, and how we prioritize those in greatest need and those based on prognosis of recovery, etc. It’s important to see that equality does not mean sameness, it means treating like cases alike. And to protect equal dignity, we want to avoid any slippage into quality of life considerations. But that shouldn’t paralyze us into treating everyone ‘the same’ understood as [the] inability to prioritize [based] on relevant consideration[s].”

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43 *Id.*

44 Email from Anderson to LiMandri, ¶ 6.