



Rights of Persons with Disabilities to Medical Treatment During the COVID-19 Pandemic

Statement from the Ethics and Public Policy, Board Committee of the
National Catholic Partnership on Disability, April 7, 2020

We are faced with challenges of significant proportion that can impact, in a unique way, persons with disabilities. However, persons with disabilities have the same rights as every human being in the allocation of limited medical resources (e.g., access to ICU beds or ventilators), in the face of a pandemic. As The Office of Civil Rights of the U.S. Department of Health and Human Services has recently reminded us, America's basic civil rights laws, including the *Americans with Disabilities Act*, prohibit discrimination based on race, color, national origin, *disability*, age, sex, exercise of conscience and religion:

[P]ersons 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. 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.¹

In other words, triage policies (policies for determining the priority of treatment to persons based on severity of their conditions) and Do Not Resuscitate (DNR) policies are to be determined on "an individualized assessment of the patient based on the best available objective medical evidence." Thus, non-arbitrary, non-discriminatory policies must recognize the innate dignity of every human being, as articulated by our Catholic tradition:

[T]his is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.²

No human being should be denied care. Concerning specific medical treatments, the principle of justice demands that its allocation, including efforts at resuscitation, must be based on objective, documentable major organ function criteria, applied consistently and without exceptions or exemptions. In other words, initial and repeatable assessment of each patient based on one's ability to benefit from the treatment, not one's current or anticipated "quality of life," is required. For example, if an adult man with Down syndrome, who has significant cognitive impairment but no major organ deficits, presents with compromised respiratory function due to COVID-19, he should not be denied a ventilator based on an ethic that others who can contribute more to society upon recovery are more deserving.

While Do Not Resuscitate orders can be implemented with patient (or designated decision-maker) consent, increasingly there are reports of the denial of resuscitation against consent. There are times in which medical treatment would be futile and cause more harm than benefit to the person. However, such decisions must be made after review of objective physiological criteria, evaluated by persons not directly involved in the case, or in the caring for others competing for the same resources. For example, a 45-year-old with quadriplegia and respiratory failure is not likely to survive COVID-19, despite the family's desire that "everything be done." However, families need to be provided with transparent, publicly accessible policies, including options for legal appeal, as well as given the option to transfer care to other providers they identify.

In times of limited resources, society must still strive to serve the good of each human being. However, such allocation decisions never should be made based on the social worth of a human being. As a society the concept of solidarity with fellow human beings dictates that any DNR or triage policy must treat each person as a unique irreplaceable human being. This applies to all human beings, including persons with disabilities. They have a right to have access to, and impact, transparent resource allocation policies, to ensure they are based on measurable, objective clinical criteria that can indicate whether each individual being evaluated can benefit from limited medical resources.

Every patient is worth treating, but not every medical treatment is worth providing. This determination must be based on an evaluation of the potential success of the treatment, not a value judgement about the person requiring aid. All people at all times are worthy of care and compassion, as well as an assessment of what available treatment could best address their immediate medical issue.

"Even the weakest and most vulnerable, the sick, the old, the unborn and the poor, are masterpieces of God's creation, made in his own image, destined to live forever, and deserving of the utmost reverence and respect." Pope Francis, Day for Life Message, July 2013.

¹ Office of Civil Rights, U.S. Dept. of Health and Human Services, BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) (March 28, 2020).

² U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th Ed. (2018), Part One.