Preventing Discrimination in the Treatment of COVID-19 Patients: The Illegality of Medical Rationing on the Basis of Disability

March 25, 2020

As the COVID-19 crisis amplifies in the United States, the Disability Rights Education and Defense Fund ("DREDF") reminds lawmakers and providers of health care, education, transportation, housing, and other critical services of their duty to uphold the civil and human rights of people with disabilities.

In the face of a public health crisis, where projections show that the need for intensive medical care for individuals made ill by COVID-19 may far exceed the resources of the U.S. healthcare system, the inclination of healthcare providers may be to take "rationing" measuresor rather, make decisions about who should or should not receive care and, if they do, what level of care. While COVID-19 poses a serious challenge to the capacity and resources of our healthcare system, DREDF reminds healthcare providers that longstanding federal and state nondiscrimination laws, such as the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act ("ACA"), the California Unruh Civil Rights Act, and California Government Code Section 11135, prohibit such rationing measures when they result in the denial of care on the basis of disability to an individual who would benefit from it.

I. The Legal Obligations of Healthcare Providers to People with Disabilities

Virtually all healthcare providers in the United States are subject to the disability nondiscrimination mandates of the ADA,[1] Section 504,[2] and/or Section 1557 of the ACA.[3] Medical providers, offices, and hospitals operated by a state or local government are subject to Title II of the ADA,[4] and private medical providers, offices, and hospitals are subject to Title III of the ADA.[5] All healthcare providers and facilities that accept federal financial assistance (including Medicare and Medicaid reimbursements) and all facilities operated by federal agencies are covered by Section 504 of the Rehabilitation Act.[6] Additionally, all health care programs and activities, any part of which accept federal financial assistance (including most private healthcare providers and insurance companies), are subject to Section 1557 of the ACA.[7]

The text of the ADA, Section 504, and their implementing regulations, prohibit discrimination across a wide range of essential contexts. This broad coverage is consistent with Congress' intent to provide "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," particularly in "critical areas" such as "health services."[8] In passing the ADA, Congress explicitly recognized the need to address discrimination in the provision of medical treatment.[9] Affirming this statutory language and the intent behind it, the U.S. Supreme Court in *Bragdon v. Abbott* confirmed the ADA's applicability to medical providers and their decisions.[10]

Disability nondiscrimination law prohibits covered entities from both treating an individual with a disability differently because of their disability or engaging in practices that disproportionately harm people with disabilities. Notably, as recognized by the Supreme Court, Congress intended disability nondiscrimination protections to reach not only discrimination that is the result of "invidious animus," but also of "thoughtlessness," "indifference," and "benign neglect."[11] The implementing regulations make clear that illegal discrimination includes providing "an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the

same level of achievement" as that provided to people without disabilities;[12] and also "eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity."[13] No provision in the ADA, Section 504, or Section 1557 of the ACAnor in any other federal law[14] authorizes the waiver of these requirements during a public health emergency.[15]

A. Categorical Exclusions from Medical Treatment on the Basis of Disability

In interpreting the ADA and Section 504, federal courts have held that the categorical denial of medical treatment on the basis of disability violates nondiscrimination law.[16] For example, the U.S. Court of Appeals for the Third Circuit has held that the exclusion of a person with a disability from a health care facility by reason of their disability violates the ADA and Section 504.[17] In *Wagner v. Fair Acres Geriatric Center*, the Third Circuit considered whether it was discriminatory to deny an individual with Alzheimer's Disease access to a skilled nursing facility because of her pre-existing condition and the correlated increased level of care that she would require.[18] The court, considering the statutory and regulatory framework of the ADA and Section 504 and their intended purposes, concluded that this categorical denial of health care servicesby reason of the plaintiff's chronic conditionconstituted a violation of disability nondiscrimination law.[19]

The U.S. Court of Appeals for the Ninth Circuit has also explicitly recognized that health care programs that exclude benefits by reason of a disability constitute facial disability discrimination.[20] In *Lovell v. Chandler*, the Ninth Circuit held that a State health care policy that excluded people who were aged, blind, or disabled from a new managed care program violated Section 504 and the ADA.[21] The State had sought to transition its Medicaid enrollees and State Health Insurance Program ("SHIP") enrollees from fee-for-service ("FFS") to a single managed care plan.[22] However, it categorically excluded people who were blind or disabled from the new managed care plan.[23] The State allowed Medicaid enrollees with disabilities to remain in their old FFS plan; however, SHIP enrollees with disabilities would be left without any coverage.[24] The Ninth Circuit overturned the policy.[25] The exclusion, on its face, applied less favorably to people who were blind and disabled, and thus it violated nondiscrimination law.[26]

ollowing the precedent set in cases such as *Wagner* and *Lovell*, the categorical exclusion of people with disabilities or chronic conditions from COVID-10 treatment, whether on an ndividual or program-based level, would violate the ADA, Section 504, andby extensionSection 1557 of the ACA (referencing Section 504's grounds of discrimination). Like in *Wagner*, if a healthcare provider were to deny care to, or place a lower relative priority for care on, a person with a disability by reason of their pre-existing condition, then such an action would constitute illegal discrimination. Furthermore, like in *Lovell*, program-wide exclusions on the basis of disability would also violate disability nondiscrimination law. While the facts of neither *Wagner* nor *Lovell* were situated within a public health emergency, their principles apply not *even* nowbut *especially* now. People with disabilities face a particularly high risk of being fatally impacted by COVID-19. Pursuant to the equality principles set forth in the passage of the ACA, the civil rights of this historically marginalized group of people must be fiercely protected. To fail to do so would not only be a failing of ethical principle, but a clear violation of long-established nondiscrimination law.

B. Facially Neutral Healthcare Policies that Disproportionately Harm People with Disabilities

Facially neutral policies that disparately impact the ability of people with disabilities to access or benefit from health care treatments also violate the ADA, Section 504, and Section 1557 of the ACA. In *Alexander v. Choate*, the U.S. Supreme Court announced the proper standard for analyzing health care practices that have a disparate impact on people with disabilities.[27] The Court held that disabled beneficiaries cannot be denied "meaningful access" to health care benefits.[28] Under the facts at hand in *Choate*, which involved a 14-day hospitalization limit within a state Medicaid program, the Court held that there was no denial of meaningful access because, in part, the evidence showed that 95 percent of disabled insureds would be served under the policy.[29] Critically, however, the Court left open the possibility that other health care practices could violate the nondiscrimination law.[30] In particular, it emphasized that policies that "apply to only particular handicapped conditions;" those that "take[] effect [based on a] particular cause of hospitalization[];" or those that prevent conditions "uniquely associated with the handicapped or occurring with greater frequency among them" from being "effectively treated, at least in part," could violate Section 504.[31]

The U.S. Court of Appeals for the Ninth Circuit, building upon the precedent set in *Choate*, has repeatedly held that "meaningful access" to health care is denied when a policy disproportionately burdens disabled people, so as to effectively reduce their access to services, programs, or activities that are accessible to others.[32] For example, in *Rodde v. Bonta*, the Ninth Circuit considered whether a county's decision to close a medical facility that disproportionately provided services to disabled people constituted violated the ADA.[33] The facility was the only one in the county that provided specialized rehabilitative services primarily (but not exclusively) to disabled people.[34] The Ninth Circuit, citing *Choate*, held that the county's plan denied meaningful access to health care:

> Eliminating entirely the only hospital of six that focuses on the needs of disabled individuals . . . and that provides services disproportionately required by the disabled and available nowhere else in the County is simply *not* the sort of facially neutral reduction considered in *Alexander*. *Alexander* may allow the County to step down services equally for *all* who rely on it for their health-care needs, but it does not sanction the wholesale elimination of services relied upon disproportionately by the disabled because of their disabilities.[35]

The closure of the facility "would deny certain disabled individuals meaningful access to government-provided services because of their unique needs," it concluded.[36] Thus, it would violate disability nondiscrimination law.[37]

Rodde applies with equal force to COVID-19 treatment policies and practices. Any hospital, provider, or government policy pertaining to the treatment of COVID-19 that would disproportionately harm or deny care to people with disabilities would constitute illegal discrimination. Like in *Rodde*, disabled individuals cannot be deprioritized or disproportionately denied care because of a facially-neutral policy. The needs and health of people with disabilities, just like any other person, must be considered when developing and implementing COVID-19 treatment policies.

C. Quality of Life Considerations

Finally, medical treatment exclusions or limitations that are based on considerations of the quality of life of a person with a disability violate the ADA, Section 504, and Section 1557 of the ACA. For example, shortly following the passage of the ADA, the state of Oregon proposed a revision to their Medicaid demonstration that would have expanded Medicaid to all individuals below the federal poverty line; however, to pay for it, they proposed a system of healthcare rationing.[38] Under the plan, Oregon would have developed a healthcare prioritization system that relied on three criteria: the probability of death, the probability of returning to an asymptomatic state, and the cost of avoiding death.[39] From a disability perspective, there were clear concerns over the disparate impact this plan would have had on the rights of patients with disabilities in need of life-saving or life-sustaining treatment. The U.S. Department of Health and Human Services, listening to the well-voiced concerns of disability advocates, rejected Oregon's proposal on grounds that it would violate the ADA and Section 504.[40] The Department specifically objected to the plan's use of quality-of-life criteria because they "quantify stereotypical assumptions" about people with disabilities and thus are impermissible factors on which to base the priority and funding of health care services.[41]

In the face of the COVID-19 crisis, misguided considerations of the quality of life of a person with a disability can similarly constitute an unjustified and unlawful implementation of a healthcare rationing system. While we recognize that the healthcare system will be strained during these difficult times, treatment decisions and overarching policies may still not discriminate.

II. Recommendations to Healthcare Providers in the COVID-19 Crisis

As detailed above, the denial or limitation of medical resources to an individual on the basis of their disabilitynot only, but especially in the case of a public health emergencywould violate disability nondiscrimination laws. In order to remain in compliance with the law, healthcare providers must adhere to the following basic principles:

A. Providers Cannot Deny or Limit Care to Disabled People Because of Their Disability

The presence of a disability or chronic condition cannot be the basis for the denial of treatment for COVID-19 or its symptoms. Any such use of the presence of a disability to deny or limit an individual's access to health care or to provide them a lower relative priority in accessing scarce resources or supplies constitutes a clear violation of disability nondiscrimination law. Similarly, the likelihood that an individual will acquire a disabling condition should they survive the virus is an impermissible and discriminatory consideration for the provision of treatment.

B. Providers Cannot Deny or Limit Care Based on the Fact That A Disabled Person May Have A Lower Likelihood of Survival or Require More Intensive Care

In enacting the ADA and subsequent civil rights legislation specific to the health care setting, Congress affirmed that principles of equality are more important than the efficiency of systems. Despite the COVID-19 crisis, this principle remains appropriate and the law of the land.

While a healthcare provider does not have a duty to provide treatment when there is objectively *no chance* of it succeeding (i.e., it is "absolutely futile"[42]), they cannot exclude from treatment people whose underlying disabilities mean that they have a *lower* probability of survival or those who, because of their disabilities, may require a higher level of care.

Prioritizing people without pre-existing conditions, who may have a higher probability of survival, would be inappropriate and constitute illegal disability discrimination. While providers are not obligated to deliver objectively futile care, they cannot discriminate against disabled people who could benefit from treatment.

Furthermore, while healthcare providers may prioritize people with a greater urgency of need, they cannot give lower relative priority to individuals whose anticipated intensity of care or resources exceeds that of other current or anticipated patients. When dealing with patients with a similar level of treatment urgency, providers should maintain their existing practice of "first come, first serve," rather than prioritizing people who would require the fewest resources.

C. Providers Must Not Rely on Quality of Life Judgments When Deciding Whether to Deny or Limit COVID-19 Treatment

Healthcare providers can misperceive the quality of life that a person with a disability experiences. Several studies have demonstrated that providers' opinions about the quality of life of a person with a disability significantly differ from the actual lived experiences of those individuals.[43] For example, one recent study found that only 18 percent of emergency care providers expressed that they would be glad to be alive after experiencing a spinal cord injury, in contrast to the 92 percent of actual spinal cord injury survivors who report a high quality of life.[44] Another study found that, when surveyed and without being given any further information about the patient's circumstances, 72 percent of physicians would deem mechanical ventilation "futile" for a "30-year-old quadriplegic patient with malignant melanoma who becomes unconscious."[45] Yet another study found that 71 percent of pediatric residents question whether aggressive treatment should be used on children with severe disabilities.[46] Providers often perceive people with disabilities to have a low quality of life when, in reality, most report a high quality of life and level of happiness, especially when they have access to the health care services and supports that they need to equally participate in and contribute to their communities.[47]

In this time of crisis, when the healthcare system will be strained, it is critical to emphasize that the lives of people with disabilities are inherently valuable and, under the law, they have an equal right to health care treatment. Many disabled individuals and their families are concerned that they will face discrimination based on ill-informed assumptions that their lives are not worth living, or that their treatment is not a "worthy" use of scarce resources.
These considerations are inappropriate and would violate disability nondiscrimination law. Instead, healthcare providers must only rely on objective, evidence-based criteria in making treatment decisions.

D. Providers Cannot Deny or Limit Treatment to A Person with a Disability Because They May Require Reasonable Accommodations

The ADA, Section 504, and Section 1557 of the ACA all require covered entities to provide reasonable accommodations for people with disabilities. Denying or giving an individual a lower relative priority for care because they may require additional support to, for example, communicate with providers, access facilities, or maintain compliance during and after treatment, would constitute illegal discrimination on the basis of disability.

Additionally, as a key component of preparing for anticipated shortages, hospitals and other healthcare facilities should proactively anticipate the need to ensure physical accessibility and to provide procedural or programmatic accommodations while administering COVID-19 treatment. Hospital policies and procedures should be timely reviewed to ensure compliance with disability rights laws. One example of a hospital policy that may need review pertains to the use of patient-owned medical equipment, such as continuous positive airway pressure units ("CPAPs"), bi-level positive airway pressure units ("BiPAPs"), mechanical ventilators, and customized mobility equipment, in the medical facility. Some hospitals prohibit, while others permit (with or without conditions, such as a pre-check of the equipment), the use of such specialized equipment during hospital stays.[48] To accommodate patients with disabilities, facilities that currently prohibit the use of outside equipment could adopt a policy *permitting* patients to use their own individualized equipment throughout hospitalization. This would not only benefit the patient, but also simultaneously conserve the hospital's own equipment supplies and treatment capacity. Note, however, that *requiring* people with disabilities, as opposed to non-disabled people, to bring or use their own equipment as a condition for receiving treatment would violate nondiscrimination law. As another example, medical facilities should allow patients to be accompanied by their trusted and trained personal care assistants should they need it. This would not only ensure that the needs of the patient are safely met, but it could enable the facility to conserve its human resources.

Hospitals and clinics can accommodate patients with disabilities by ensuring that COVID-19 treatment policies, such as those limiting hospital admittance, explicitly allow for the reasonable modifications and exceptions needed by people with various disabilities and of all ages.

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While we recognize that the COVID-19 crisis places capacity and resource strains on the U.S. healthcare system, decisions on who should or should not receive care or who should be prioritized for care, cannot disadvantage or cause the disproportionate death of people with disabilities. Providers may, of course, prioritize individuals with a greater urgency of need and delay non-urgent care, but they may not set aside the principles of disability nondiscrimination law in doing so.

The lives of people with disabilities are equally valuable to people without disabilities, and *no one* should face discrimination in the provision of life-saving care. The rationing of health care services away from people with disabilities or chronic conditions during this time of crisis is not only ethically wrong, it is illegal. We must serve and protect all people in the United States during this time of emergency.

[1] 42 U.S.C. 1210112213 (2010).

[2] 29 U.S.C. 794.

[3] 42 U.S.C. 18116.

[4] *Id.* 12131(1) (public entities include "any State or local government" and "any department, agency, special purpose district, or other instrumentality" of such governments), 12132 '[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."); *see also* 28 C.F.R. Part 35, App. B, 35.102 ("title II applies to anything a public entity does").

[5] 42 U.S.C. 12181(7)(F) (a "professional office of a health care provider, hospital, or other service establishment" are public accommodations), 12182(a) ("No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation"); *accord* 28 C.F.R. 36.104.

[6] *See* 29 U.S.C. 794.

[7] 42 U.S.C. 18116.

[8] *Id.* 12101(a)(3), 12101(b),

[9] S. Rep. No. 101-116 (1989) (Committee on Labor and Human Resources), at 7 ("The U.S. Commission on Civil Rights recently concluded that: 'Despite some improvements * * * [discrimination] persists in such critical areas as . . . medical treatment[.]'"); H.R. Rep. 101-485(II) (1990) (Committee on Education and Labor), at 31, *as reprinted in* 1990 U.S.C.C.A.N. 303, 312 (same); H.R. Rep. 101-485(III) (1990) (Committee on the Judiciary), at 38, *as reprinted in* 1990 U.S.C.C.A.N. 445, 460-61 ("It would not be permissible . . . to deny coverage to individuals . . . with kidney disease or hemophilia for other [covered] procedures or treatments connected with their disability. . . . [P]eople with disabilities must have equal access to health insurance coverage."); Testimony before Senate Subcommittee on the Handicapped, S. Hrng. 101156, May 10, 1989, p. 100 (Robert Burgdorf, Jr., Professor of Law at the District of Columbia School of Law, testifying that "it makes no sense to bar discrimination against people with disabilities in theaters, restaurants, or places of entertainment but not in regard to such important things as doctor's offices. It makes no sense for a law to say that people with disabilities cannot be discriminated against if they want to buy a pastrami sandwich at the local deli but that they can be discriminated against next door at the pharmacy where they need to fill a prescription. There is no sense to that distinction."); National Disability Rights Network, *Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights* 49 (May 2012), *available at* https://www.ndrn.org/images/Documents/Resources/Publications/Reports/Devaluing_People_with_Disabilities.pdf.

[10] 524 U.S. 624, 64855 (1999) (delineating and applying substantive standards of ADA to private medical provider's decision to refer an HIV-positive patient to another medical facility, and remanding for further review under such standards); *see also* Samuel R. Bagenstos, *May Hospitals Withhold Ventilators from COVID-19 Patients with Pre-Existing Disabilities? Notes on the Law and Ethics of Disability-Based Medical Rationing* (Mar. 24, 2020), at 1215 (discussing caselaw), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3559926.

[11] *See* Alexander v. Choate, 469 U.S. 287, 29596 (1985).

[12] 28 C.F.R. 35.130(b)(1)(iii) (2010).

[13] *Id.* 35.130(b)(8).

[14] 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, 73739 (May 2011) (reviewing federal statutes relating to public health emergencies and concluding that they reflect "a commitment to equal access, even in the context of an emergency").

[15] *See* Disability Rights Washington, *Disability Discrimination Complaint Filed Over Covid-19 Treatment Rationing Plan in Washington State* (Mar. 23, 2020), *available at* https://www.disabilityrightswa.org/2020/03/23/disability-discrimination-complaint-filed-over-covid-19-treatment-rationing-plan-in-washington-state/.

[16] *See, e.g.,* In re Baby K, 832 F. Supp. 1022, 102829 (E.D. Va. 1993), *aff'd on other grounds,* 16 F.3d 590, 592 (4th Cir. 1995) (holding that "the plain language of the ADA does not permit the denial of ventilator services that would keep alive an anencephalic baby when those life-saving services would otherwise be provided to a baby without disabilities at the parent's request. The Hospital's reasoning would lead to the denial of medical services to anencephalic babies as a class of disabled individuals. Such discrimination against a vulnerable population class is exactly what the American with Disabilities Act was enacted to prohibit.").

[17] Wagner v. Fair Acres Geriatric Ctr., 49 F.3d 1002, 100509 (3d Cir. 1995).

[18] *Id.*

[19] *Id.*

[20] Lovell v. Chandler, 303 F.3d 1039, 1052 (9th Cir. 2002).

[21] *Id.*

[22] *Id*. at 1045.

[23] *Id.*

[24] *Id.*

[25] *Id.* at 105254.

[26] *Id.*

[27] 469 U.S. 287, 301 (1985).

[28] *Id.* at 30103.

[29] *Id.*

[30] *See id.*

[31] *Id.* at 302n.22.

[32] *See* Rodde v. Bonta, 357 F.3d 988, 99798 (9th Cir. 2004); *see also* Crowder v. Kitagawa, 81 F.3d 1480, 148485 (9th Cir. 1996).

[33] 357 F.3d at 99798.

[34] *Id.*

[35] *Id.* at 997 (emphasis in original).

[36] *Id.* at 998.

[37] *Id.*

[38] *See* Timothy B. Flanagan, *ADA Analyses of the Oregon Health Care Plan,* 9 Issues L. & Med. 397, 397412 (1994); *The Oregon Health Care Proposal and the Americans with Disabilities Act*, 06 Harv. L. Rev. 1296, 12961313 (April 1993).

[39] Flanagan, *supra* note 38, at 40912; *The Oregon Health Care Proposal*, *supra* note 38, at 12961313.

[40] Flanagan, *supra* note 38, 40912; *The Oregon Health Care Proposal*, *supra* note 38, at 12961313.

[41] *The Oregon Health Care Proposal*, *supra* note 38, at 1296.

[42] Sigrid Fry-Revere, et al., *Death: A New Legal Perspective*, 27 J. Contemp. Health L. & Pol'y 24, 2425 (2010).

[43] Mary Crossley, *Ending-Life Decisions: Some Disability Perspectives*, 33 Ga. St. Univ. L. Rev. 900, 90001 (2017).

[44] Silvia Yee, Mary Lou Breslin, et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, Nat'l Acads. Scis., Eng'g, & Med. 42 (2017), *available at available at* http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities.

[45] Robert Powell Ctr. for Medical Ethics, Nat'l Right to Life Comm., *Will Your Advance Directive Be Followed?* (June 2017), *available at* https://www.nrlc.org/uploads/medethics/WillYourAdvanceDirectiveBeFollowed.pdf; Crossley, *supra* note 43, 198202.

[46] Yee & Breslin, *supra* note 44, at 42.

[47] Crossley, *supra* note 43, at 90001.

[48] ECRI, *Patient-Owned Equipment*, 3 Healthcare Risk Control, no. 8 (May 2004), *available at* http://uthscsa.edu/gme/documents/SupportDocument-ECRIPatientOwnedEquipment.pdf.

13 thoughts on “Preventing Discrimination in the Treatment of COVID-19 Patients: The Illegality of Medical Rationing on the Basis of Disability”

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Jean Stewart
April 5, 2020 at 3:14 pm

I’d like to write a letter–and I encourage others to do likewise–re medical rationing on the basis of disability or age, using your brilliant document as my reference point…My question is, to whom would I/we most appropriately direct such a letter? In whose hands are letters most likely to have impact? I guess even if they have no impact whatsoever, the writing of them may help mitigate this overwhelming sense of hopeless powerlessness. What fills me with horror is the image of all those elderly and disabled folks, alone in ICUs, no loved ones at bedside, whose lives were ended or are about to end, in Italy and Spain and New York and California and everywhere, taken off vents (or never assigned them) because they are considered less worthy. Dying alone. Lebensunwertes lebens.

Thank you, DREDF, for tackling this profound iniquity. Bless you.

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Pingback: When the Whole World is Homebound – Spastic Mama

Ralene Reyes
March 27, 2020 at 4:05 pm

I was denied treatment for possible exposure and not having the test result back. I have asthma and have had 3 medical visits(hospital and urgent care) and 2 in which I needed a breathing treatment. My Dr office wouldn't answer the phone as as the ER Dr told me told me to advocate for myself and go in and ask for a nebulizer or an appointment to get one. I was told by the MA at my Dr office that I needed to leave, I shouldnt be walking around going to places and exposing people and implied I was being reckless by going there to ask for assistance when I should have called. I explained I called all previous times and I couldn't get through. My asthma was bad to where I fainted from trying to breath and my rescue inhaler isn't working. She persisted in telling me what I'm doing is not smart and I should think about others health and myself and she stated she is not being overboard or extra cautious, it's the truth. I was denied by one urgent care office to be seen unless I had my results back and would only do a virtual appointment which doesn't make sense when u needed a breathing treatment.

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Amy Osteen
March 26, 2020 at 12:49 pm

Yes! Please let me know if you need any pro bono work to help with the cause.

Pingback: Updates on Senate Bill, Crip Camp, Healthcare Rationing, and More