American Journal of Law & Medicine (2024), 50: 3-4, 298–305
doi:10.1017/amj.2025.14

American Society of Law, Medicine & Ethics
Where Multidisciplinary Education Improves Practice

ARTICLE

Disability's Role in Health Law

Mary Crossley*

University of Pittsburgh School of Law, Pittsburgh, PA, USA
Email: crossley@pitt.edu

Abstract

Today, considerations of disability are a vital part of health law scholarship and teaching, but that was not always the case. This Essay traces how disability's role in health law has grown over the past three decades, alongside the author's own evolution as a health and disability law scholar. The recent official designation of disabled people as a health disparities population is encouraging, but much work remains to achieve health equity for disabled persons.

Keywords: disability discrimination; social model of disability; disability studies; health equity; Americans with Disabilities Act

On September 26, 2023, the fiftieth anniversary of the passage of Section 504 of the federal Rehabilitation Act of 1973, the National Institute on Minority Health and Health Disparities designated people with disabilities as a health disparities population.[1] On May 1, 2024, the federal Department of Health and Human Services ("HHS") finalized a new rule applying Section 504's prohibition of disability discrimination to health care programs receiving federal funding.[2] Among other provisions, the regulation clarifies that decisions to limit medical treatment based on a belief that a disabled patient will be a burden or that the patient's life is not worth living constitute violations of federal law.[3] At the June 2024 Health Law Professors Conference sponsored by the American Society of Law, Medicine & Ethics, nearly ten percent of concurrent sessions included presentations addressing some aspect of disability relating to health law.[4] Today, consideration of disability has become an integral aspect of health law and policy, particularly with respect to concerns regarding health equity and health justice.

It wasn't always so. This Essay reflects on both the path by which disability has developed into a vital part of health law and my own evolution as a health and disability law scholar. These paths track one another, with disability (and disability law scholarship) going from being something of an outsider to the health law community to having a seat at the table.

---

*Mary Crossley is Professor of Law, and John A. Murray Faculty Scholar at the University of Pittsburgh School of Law and is the author of *Embodied Injustice: Race, Disability, and Health* (Cambridge 2022).

[1] Eliseo J. Pérez-Stable & Robert Otto Valdez, *Announcement of Decision to Designate People with Disabilities as a Population with Health Disparities*, Nat'l Inst. on Minority Health & Health Disparities (Oct. 31, 2023), https://www.nimhd.nih.gov/about/directors-corner/messages/health-disparities-population-designation.html [https://perma.cc/J5L9-4ZHW].

[2] *HHS Finalizes Rule Strengthening Protections Against Disability Discrimination*, U.S. Dep't of Health & Hum. Servs. (May 1, 2024), https://www.hhs.gov/about/news/2024/05/01/hhs-finalizes-rule-strengthening-protections-against-disability-discrimination.html.

[3] 45 C.F.R. § 84.56(b)(1) (2024).

[4] *Schedule: June 5–7, 2024*, Health L. Professors Conf., https://healthlawprofconf.org/schedule/ [https://perma.cc/2BKJ-NLDY] (last visited Nov. 3, 2024) (based on a count that four out of forty-nine concurrent sessions included presentations relating to disability).

Starting down the path: Baby Doe and early questions about disability in health care settings

When I first started writing about medical treatment decisions for disabled patients in 1985, I was a law student, and I didn't know what I was getting myself into. (Today, I warn my seminar students to be careful when choosing their paper topics, as the choice could shape the trajectory of their entire careers!) The Bloomington, Indiana Baby Doe case was the inspiration for my law school seminar paper, which I eventually published.[5] In 1982, parents of a newborn with Down syndrome and an esophageal atresia (blockage) followed their doctor's advice and withheld consent for routine surgery to correct the blockage and permit the baby to take nutrition and hydration.[6] From today's perspectives, many would find chilling a decision to withhold treatment so as to allow a baby to die based on a Down syndrome diagnosis. In that era, articles in the medical literature suggested that many pediatricians deemed this approach appropriate.[7] To anyone attuned to disability perspectives, the language often used to describe these decisions ("selective nontreatment of defective newborns") reeks of ableism. When I wrote this first paper, I was not at all attuned to disability perspectives. In rereading this early effort, I cringe to find that I used the phrase "defective newborns" to describe infants born with a disabling impairment.

In 1982 the law proved powerless to do anything to protect the baby, who died six days after being born.[8] The case, however, prompted action by the Reagan Administration's Department of Health and Human Services, which promulgated an interim final rule under Section 504 that established a "Handicapped Infant Hotline," called on hospitals to post warnings against discriminatory non-treatment decisions in infant care settings, and prompted the creation of so-called "Baby Doe squads" to investigate suspected cases of treatment denials.[9] The courts, however, were not going along with attempts to use Section 504 to prevent the withholding of medical treatment from disabled infants. In a 1984 case involving the withholding of care from an infant born with spina bifida and other conditions, the Second Circuit concluded that Congress did not intend for Section 504 to apply to medical decision-making.[10] The court reasoned that a medical treatment decision could not be considered discriminatory "[w]here the handicapping condition is related to the condition(s) to be treated."[11] Two years later, the Supreme Court struck down the Section 504 regulations, finding that the administrative record of discriminatory conduct by hospitals was insufficient to support them.[12] It was ultimately not health law or anti-discrimination law, but child welfare law, in the form of 1984 amendments to the Child Abuse Prevention and Treatment Act, that provided a legal mechanism for addressing parental choices to withhold treatment by characterizing those choices as a species of parental neglect.[13]

The ADA gives disability discrimination law greater visibility

By 1992, I was a newbie law professor trying to figure out what I should write my first article about (this was back in the day when new law professors did not typically emerge from fellowship programs with carefully vetted multi-page scholarly agendas). I was scanning the table of contents of the Journal of the

---

[5] Mary A. Crossley, *Selective Nontreatment of Handicapped Newborns: An Analysis*, 6 Med. & L. 499 (1987).

[6] *Id.* at 503, 519 n.82.

[7] *See, e.g.*, Raymond S. Duff & A.G.M. Campbell, *Moral and Ethical Dilemmas in the Special Care Nursery*, 289 New Eng. J. Med. 890, 890 (1973); John M. Freeman, *Is There a Right to Die — Quickly?*, 80 J. Pediatrics 904 (1972).

[8] Linda C. Fentiman, *Health Care Access for Children with Disabilities*, 19 Pace L. Rev. 245, 251 (1999).

[9] Nondiscrimination on the Basis of Handicap, 48 Fed. Reg. 9630–32 (Mar. 7, 1983) (to be codified at 45 C.F.R. § 84.55). For a discussion of "Baby Doe squads," see Gregory Pence, Classic Cases in Medical Ethics 220–222 (McGraw-Hill, 4th ed. 2004) (1990); Jeff Lyon, Playing God in the Nursery 42–44 (1985); Fentiman, *supra* note 8, at 251–52.

[10] United States v. Univ. Hosp., 729 F.2d 144, 157 (2d Cir. 1984).

[11] *Id.*

[12] Bowen v. Am. Hosp. Ass'n, 476 U.S. 610, 643-47 (1986).

[13] Child Abuse Amendments of 1984, 42 U.S.C. § 5103(b)(2)(K) (repealed 1996) (current version substantively at 42 U.S.C. § 5106a(b)(2)(C)) (premising award of federal grants to State child abuse and neglect prevention and treatment programs in part on the State's provision of laws and procedures enabling State child protective services system to pursue legal remedies to "prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions").

American Medical Association ("JAMA"), seeking inspiration and ideas, when I stumbled upon an article reporting on a survey indicating that a significant number of neonatal care providers would be unlikely to recommend aggressive treatment for a life-threatening condition for a newborn at risk of having HIV.[14] Hearing an echo of the story that I had wrestled with as a law student, and being vaguely aware of the Americans with Disabilities Act's ("ADA's") recent enactment, I decided to explore how the new law might apply to non-treatment decisions, specifically in the context of infants who had been exposed to HIV. More generally, the article considered "how can the concept of disability discrimination be meaningfully applied in the context of individual medical treatment [decisions]?"[15]

This exploration led me to conclude that the ADA's prohibition of disability discrimination must apply to at least some medical decisions influenced by a patient's disability. I specifically advocated for what I called a "medical effects approach," which would read the ADA to prohibit treating a disabled patient differently based solely on the disability alone, but would permit medical decision makers to consider the medical effects of a patient's disability in deciding what treatment to provide.[16] As I worked on this article, it became clear to me that determining when and how disability discrimination law properly applied to medical decisions was complex and requires a nuanced understanding of the interplay between disability, health, and the law.

After writing that first article, I realized that questions about disability lurked in the shadows of many issues being debated in the bioethics and health law literatures during the 1990s. And thus, my cottage industry in "how does (or should) disability discrimination law speak to *X*" began.[17] I knew I was on to something very quickly. In 1992, the Secretary of HHS rejected Oregon's proposed plan to incorporate explicit rationing of services into its Medicaid program, reasoning that the proposal conflicted with the ADA because its prioritization of services for coverage appeared to be based on "the premise that the value of the life of a person with a disability is less than the value of the life of a person without a disability."[18] HHS's reliance on the ADA to constrain Oregon's rationing proposal confirmed my sense that maybe the law could make a difference in the care that patients with disabilities receive.

A continued scarcity of companions on the path

When I started down the path of writing about disability and health, it was not yet well-traveled. Many of the scholars whose work I initially relied on hailed from family law; others worked in bioethics. Most of these scholars centered their inquiries on parents' autonomy, physicians' authority, and children's interests in living. Law and bioethics scholars writing about problems involving disabled patients tended to reflect what Professor Carl Schneider referred to as a hyper-rationalism that abstracted governing principles from the messiness of human lives.[19] He described the bioethics and legal literature as "too often discuss[ing] the problems of health care in so disembodied and denatured a way that the patients

---

[14] Betty Wolder Levin et al., *Treatment Choice for Infants in the Neonatal Intensive Care Unit at Risk for AIDS*, 265 J. Am. Med. Ass'n 2976 (1991).

[15] Mary A. Crossley, *Of Diagnoses and Discrimination: Discriminatory Nontreatment of Infants with HIV Infection*, 93 Colum. L. Rev. 1581, 1589 (1993).

[16] *Id.* at 1651, 1662.

[17] *See, e.g.*, Mary A. Crossley, *Medical Futility and Disability Discrimination*, 81 Iowa L. Rev. 179 (1995); Mary Crossley, *Medicaid Managed Care and Disability Discrimination Issues*, 65 Tenn. L. Rev. 419 (1998).

[18] Letter from Louis W. Sullivan, Sec'y, U.S. Dep't. of Health & Hum. Servs., to Barbara Roberts, Governor, State of Oregon (Aug. 3, 1992), *reprinted in ADA Analyses of the Oregon Health Care Plan*, 9 Issues L. & Med. 397, 409–12 (1994) (including accompanying three-page "Analysis Under the Americans with Disabilities Act ('ADA') of the Oregon Reform Demonstration"). Under Oregon's proposal, treatment for a disabling condition would be excluded from coverage, when the same therapy would be covered to treat a different, non-disabling condition. *See ADA Analyses of the Oregon Health Care Plan*, *supra*, at 411–12.

[19] Carl E. Schneider, *Bioethics with a Human Face*, 69 Ind. L.J. 1075, 1078 (1994) ("[T]he assumptions of hyper-rationalism conduce to a view of human nature that airbrushes out life's complexity and that sees human nature and conduct as verging on the uniform.").

and physicians, the family and friends, the dread and the disease are quite abstracted from the scene."[20] One aspect of that abstraction was a tendency to not pay close attention to the social contexts in which patients (or their families) made decisions[21] or to the importance of embodiment[22] (by which I mean, the experience of existing in a particular body). Scholarship that explicitly grappled with the role of the infant's disability as a disability in shaping parental and medical decisions was just beginning to emerge.

Nor did the casebook that I used for many years in teaching my Health Law and Policy course, the venerable Furrow, Greaney, Johnson, Jost & Schwartz, *Health Law*, foreground disability itself as a subject integral to learning about the legal rules affecting the health care financing and delivery system. As late as 2013, the casebook's seventh edition addressed the ADA in a chapter titled "Duties to Treat."[23] That chapter addressed a provider's duty to treat a patient needing care and started by outlining the common-law "no duty" rule that elevates physician autonomy over patient need (at least in the absence of an established doctor-patient relationship).[24] It then included the ADA (along with Title VI of the 1964 Civil Rights Act, which prohibits discrimination based on race, color, or national origin) to demonstrate a statutory incursion on the "no duty" rule.[25]

In short, for the first decade or so of my career, I had an extended identity crisis as I tried to figure out just what "kind" of scholar I was trying to become. Clearly, I taught health law and policy, and occasionally bioethics and law. The group of scholars whom I most regularly identified with were health law scholars. But the law most central to my scholarly work — disability discrimination law — was not yet widely seen as part of health law. To illustrate, in a piece written for a 2005 conference on Rethinking Health Law, Professor Einer Elhauge pondered the question of whether "health law" could even be understood as a separate field, or whether it was simply an agglomeration of multiple different fields of law applied to actors in a particular industry.[26] He reasoned:

> Unless the various parts of health law hang together conceptually, one might sensibly conclude that what lawyers need to know is not health law, but the various conceptually coherent bodies of law that are all separately relevant to the health care industry. In short, health lawyers may need to understand not just health law, but the laws of antitrust, tax, corporations, contracts, torts, ERISA, and insurance law in all their separate glory, as well as a few specialized subjects like Medicare, Medicaid, certificate of need regulation, and corporate practice of medicine law.[27]

Notably absent (to my mind) from his list of the bodies of law that health lawyers may need to understand was disability discrimination law (or any species of anti-discrimination law, for that matter). Moreover, as far as I could tell, most disability law scholars appeared to write about education or employment issues, not health care-related issues.

Feeling somewhat adrift and without a scholarly home, I nonetheless found myself irresistibly drawn to writing about how disability law should apply to contentious questions arising in medical settings. I often tell students that I find health law fascinating because it requires the law to structure and regulate a field that simultaneously involves both profound human vulnerability (we, and those we love, get sick and die, and many of us fear both events) and momentous economic impact (17.3% of the United States'

---

[20] *Id.* at 1075.

[21] *Id.* at 1078.

[22] *Id.* at 1080.

[23] Barry R. Furrow et al., Health Law: Cases, Materials and Problems 305–34 (abr. 7th ed. 2013).

[24] *Id.* at 312.

[25] *Id.* at 326–34. The current edition of the casebook, with a new generation of authors, centers the interests of disabled patients, along with patients from other groups that have been marginalized, in a chapter titled "Discrimination and Unequal Treatment in Health Care." Brietta R. Clark et al., Health Law: Cases, Materials and Problems 219–311 (abr. 9th ed. 2022). This chapter also addresses how the structure of health insurance coverage can function as a barrier to disabled patients' receipt of appropriate care. *Id.* at 308–11.

[26] Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 Wake Forest L. Rev. 365 (2006).

[27] *Id.* at 367–68.

GDP goes to health care).[28] Adding disability (another thing that many non-disabled persons fear) to the mix makes discerning the best resolution to contentious medical questions all the more challenging.

Disability Studies offers insights to health law

Pioneering scholars writing in the field of disability studies offered insights into why disability mattered to health law that were absent from the health law literature of the day. In the late 1990s, I had the great fortune to meet Anita Silvers and talk with her about her work. A pathbreaking scholar and disability rights advocate, Silvers spent her professional career in the philosophy department at San Francisco State University, and applied a feminist and disability studies lens to bioethical issues.[29] Her work, and that of other disabled scholars like historian Paul Longmore,[30] helped me begin to appreciate — from the perspective of disabled persons — the issues that engaged me and understand the meaning of disability beyond its legal definitions. Their work centered the experiences and voices of persons with disabilities.

That work also directly confronted the dominance of medicine in controlling decisions affecting the health and welfare of disabled persons. It illuminated a concept particularly important to considering the meaning of disability in health law and bioethics. In probing the meaning of disability as a phenomenon, disability studies scholars contrasted the "medical model" of disability with the "social model" of disability.[31] The medical model of disability understands disability as a problem located in a person's body; disability is a pathology or deficit that should be fixed (most often by doctors) whenever possible.[32] By contrast, the social model views disability as the product of the interaction of a person's impairment with environmental and social conditions.[33] Under the social model, mitigating the disadvantages associated with disability can best be accomplished by addressing those environmental and social conditions.[34] Today, these concepts are familiar to many legal scholars who write in bioethics or health law.

That was not the case in the 1990s. The earliest use of the phrase "medical model of disability" revealed by a search of Westlaw's Law Reviews & Journals database was in 1987.[35] Over the following eleven years (1988–1998), the phrase appeared a dozen more times. Over the eleven years after that (1999–2009), it appeared 117 times.[36] The 1990s marked a pivotal moment where a disability-informed understanding of the meaning of disability began to emerge in the legal literature. When I made my first sustained efforts in the late 1990s to suggest how insights from disability studies might change, or inform, how the law understands disability,[37] I had no idea that I was poised on the crest of a surging wave of interest in disability among health law scholars. I just knew that it was exciting and illuminating to have a new lens for looking at the many health law issues implicating disability.

Two aspects of the medical model versus social model dichotomy shaped my evolving inquiry into disability and health. The first was disability theorists' rejection of medical authority as the basis for understanding disability and even their view of the medical profession as antagonistic toward disability.

---

[28] *Historical National Health Expenditure Data*, Ctrs. for Medicare & Medicaid Servs. (Sept. 10, 2024, 6:23 PM), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical [perma.cc/L3Y2-V2B5].

[29] *See, e.g.*, Anita Silvers, *Formal Justice*, *in* Disability, Difference, Discrimination: Perspectives on Justice in Bioethics and Public Policy 13 (James P. Sterba & Rosemarie Tong series eds., 1998); Anita Silvers, *Reprising Women's Disability: Feminist Identity Strategy and Disability Rights*, 13 Berkeley Women's L.J. 81 (1998).

[30] *See, e.g.*, Paul K. Longmore, *Medical Decision Making and People with Disabilities: A Clash of Cultures*, 23 J.L. Med. & Ethics 82 (1995).

[31] *See, e.g.*, Silvers, *supra* note 29, at 59–63, 74–76.

[32] *Id.* at 59.

[33] *Id.* at 74.

[34] Mary Crossley, *Disability Cultural Competence in the Medical Profession*, 9 St. Louis U. J. Health L. & Pol'y 89, 95 (2015).

[35] Paul K. Longmore, *Elizabeth Bouvia, Assisted Suicide and Social Prejudice*, 3 Issues L. & Med. 141, 147 (1987).

[36] As this article is going to press in December 2024, the search produces 416 results.

[37] Mary Crossley, *The Disability Kaleidoscope*, 74 Notre Dame L. Rev. 621, 716 (1999).

From a disability perspective, physicians regularly violated the Hippocratic injunction to do no harm by devaluing the lives of disabled persons and failing to support non-curative, but function-enhancing, interventions. The second insight that opened new vistas for me was the social model of disability's insistence that many of the disadvantages associated with disability flow from how society constructs its physical, social, economic, and political environments, rather than being the inevitable products of individuals' bodily differences.

A simple but powerful illustration makes the concept of social construction of disability more concrete. Visualize a wheelchair-using person sitting at the bottom of a flight of stairs leading into a building, and it becomes obvious that the stairs — rather than the person's mobility impairment — exclude the person from the building. Personally, the concept also translated readily into an interest in how non-physical barriers could exclude disabled people.

From there, it was only a short step to curiosity about how other marginalized groups in our society faced socially constructed disadvantages. I became more interested in exploring the existence and explanations of racial health disparities. While learning about the experiences of Black Americans in the health care system, I was struck repeatedly by what seemed to be parallels in their experiences and the experiences of disabled Americans. Those parallels manifested in distrust of the medical profession, their disproportionate reliance on Medicaid, and their experiences of controls on childbearing.[38] Understanding the need to adopt an intersectional lens, which foregrounds the health inequities experienced by persons who are both disabled and Black, eventually presented new areas worthy of both inquiry and advocacy.[39]

A flowering of attention in the twenty-first century: the ADAAA, the ACA, and COVID-19

In the twenty-first century, several events accelerated disability's growth in prominence in health law scholarship, teaching, and practice. Two legislative milestones that occurred in the span of a few years — the Americans with Disabilities Act Amendments Act ("ADAAA")[40] and the Affordable Care Act ("ACA")[41] — boosted disability's saliency. In a health care landscape where the treatment of chronic disease increasingly occupied center stage, the broad definition of "disability" that Congress endorsed in 2008 in the ADAAA made it unmistakable that disability was pervasive in health care settings.[42] Just two years later the ACA declared that insurers could no longer treat pre-existing conditions as a basis for refusing to cover needed medical care.[43] The ACA's pre-existing condition protections are among its most popular provisions,[44] and they are particularly valuable for disabled persons. Working in tandem, these laws expanded the number of disabled people who could claim a right to accommodations in medical settings (among other rights provided by the ADA) and were protected from denials of insurance coverage.

A decade later, the global COVID-19 pandemic brought to the fore distinctive concerns felt by disabled people that reflected their distrust of, or at the least, dissatisfaction with health professions.

---

[38] MARY CROSSLEY, EMBODIED INJUSTICE: RACE, DISABILITY, AND HEALTH 70–71, 102–03, 233 (2022).

[39] *See id.* at 221–40.

[40] Americans with Disabilities Act Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified at 42 U.S.C. §§ 12101–12213) (amending Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327).

[41] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code, primarily 42 U.S.C.).

[42] 42 U.S.C. § 12102 (defining "disability" for purposes of the ADA). To be sure, not all chronic disease results in legal disability (whether that term is used in anti-discrimination laws like §504 and the ADA or in public benefits programs like Supplemental Security Income). But it regularly does, which means that legal disputes have increasingly turned on determining whether a person is entitled to the protections and benefits provided by these laws.

[43] 42 U.S.C. § 300gg-3.

[44] Ashley Kerzinger et al., *5 Charts About Public Opinion on the Affordable Care Act*, KFF (May 15, 2024), https://www.kff.org/affordable-care-act/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act/ [https://perma.cc/7A5K-6F7S].

While COVID-19 did not spare any group, distinctive threats to disabled persons emerged in the form of crisis standards of care that used disability or shorter lifespan projections to deny access to treatment, demands by hospitals that DNRs be entered before admitting some disabled patients, and tragically high rates of infection and death in the congregate care facilities where many disabled people received supportive services.[45] The adoption of crisis standards of care alleged to discriminate based on disability prompted action by the HHS Office of Civil Rights. Some of those standards also provided a vivid example of how the utilitarian bent of bioethicists (seeking to maximize life-years saved) conflicted with the justice-centered demands of disabled people and their advocates.[46] But this debate reflected that the disability perspective has changed the terms of engagement. It is no longer acceptable for bioethicists or medical providers to disregard disability perspectives.[47] Now, those perspectives must be accounted for. It seems that the disability advocates' mantra of "nothing about us without us" is becoming real.[48]

Conclusion

Today, disabled people are officially designated a health disparities population[49] and health law has a robust literature that emphasizes health justice — a term that encompasses disability justice[50]— and that accepts social construction and social drivers of health and health inequity. Leading journals in medicine and public health have begun to feature content emphasizing the need to address ableism and structural ableism in those fields.[51]

---

[45] *See* Samuel R. Bagenstos, *Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols*, 130 Yale L.J.F. 1, 2–3 (2020) (noting that, prior to HHS intervening in April 2020, several states such as Alabama, Tennessee, and Washington employed crisis standards of care that allowed for denial of care on basis of disability, age, or "baseline [pre-coronavirus] functional status"); Laura I. Appleman, *Pandemic Eugenics: Discrimination, Disability, & Detention During COVID-19*, 67 Loy. L. Rev. 329, 373–378 (2021) (discussing high rates of COVID-19 infection in congregate care facilities for individuals with intellectual and developmental disabilities and failure of many states to provide proper oversight); *see* Joseph Shapiro, *Oregon Hospitals Didn't Have Shortages. So Why Were Disabled People Denied Care*?, Natl. Pub. Radio, (Dec. 21, 2020).

[46] *Compare* Bagenstos, *supra* note 45, at 13 ("[A]llowing scarcity of ventilators[] while imposing the life-or-death costs of that scarcity most heavily on disabled people [] bespeaks a failure of democratic legitimacy."), *with* Govind Persad, *Disability Law and the Case for Evidence-Based Triage in a Pandemic*, 130 Yale L.J.F. 26, 48–50 (2020) (arguing that social origins of resource scarcity — social and political decisions to underinvest in testing and equipment — cannot justify the sacrifice of life resulting from policies of random selection and non-evidence-based triage).

[47] *Cf.* Laura Guidry-Grimes et al., *Disability Rights as a Necessary Framework for Crisis Standards of Care and the Future of Health Care*, Hastings Ctr. Rep., May/June 2020, at 28, 30 ("The Covid-19 pandemic has already brought attention to the value of disabled knowledge as society makes collective accommodations for our newly remote lives, and we call for formal inclusion of disability perspectives in institutional and governmental decision-making bodies.").

[48] *See* James I. Charlton, Nothing About Us Without Us: Disability Oppression and Empowerment 3 (1998) ("[T]he expression … 'Nothing About Us Without Us' resonates with the philosophy and history of the disability rights movement (DRM), a movement that has embarked on a belated mission parallel to other liberation movements. As Ed Roberts, one of the leading figures of the international DRM, has said, 'If we have learned one thing from the civil rights movement in the U.S., it's that when others speak for you, you lose.'").

[49] Pérez-Stable & Valdez, *supra* note 1.

[50] *See* Jasmine E. Harris, *Locating Disability within a Health Justice Framework*, 50 J.L. Med. & Ethics 663, 665 (2022) (highlighting literature authored by Professors Jessica Roberts, Sam Bagenstos, Katherine Macfarlane, Elizabeth Pendo, and Kelly Dineen exploring various intersections of health justice and disability justice).

[51] *See, e.g.*, Rupa Sheth Valdez & Bonnielin K. Swenor, *Structural Ableism – Essential Steps for Abolishing Disability Injustice*, 388 New Eng. J. Med. 1827 (2023); Dimitri A. Christakis & Lisa I. Iezzoni, *Calling on the USPSTF to Address Ableism and Structural Ableism*, 330 J. Am. Med. Ass'n 1327 (2023); Dielle J. Lundberg & Jessica A. Chen, *Structural Ableism in Public Health and Healthcare: A Definition and Conceptual Framework*, 30 Lancet Reg'l Health – Ams. art. no. 100650 (2023).

It is encouraging to see how both teaching and scholarship in the health law academy increasingly embrace health justice and recognize disability as one of the many axes of human diversity and difference deserving recognition. To be sure, the path ahead looks to be bumpy with the Supreme Court's decision discarding *Chevron* deference[52] certain to spur challenges to agency actions providing protections to disabled persons. We still have far to go in achieving health equity for disabled persons, but it is clear now that disability is understood as part of the health law family.

---

[52] Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2273 (2024) ("*Chevron* is overruled. Courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires… . [C]ourts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous.").

Cite this article: Crossley, M. (2024), 'Disability's Role in Health Law', *American Journal of Law & Medicine*, **50**, pp. 298–305. https://doi.org/10.1017/amj.2025.14