and become mere consultants on compliance committees. If a patient or clinician who is morally distressed because of abortion restrictions seeks counsel, physicians should default to the traditional role of ethics-committee members, offering succor and guidance grounded in the basic tenet of reproductive ethics that a pregnant person with decisional capacity has dominion over their reproductive choices. When the law precludes this approach, physicians should remember that one of their essential tasks as ethics consultants is to communicate responsibly about the issues they weigh.[3] They should report any untoward effects of abortion restrictions and voice their opposition to unjust laws, while ensuring that patients and clinicians are fully informed of legal encumbrances to reproductive liberty and health. As members of a moral community, they should "be trusted to stand against the values of the society in which [that moral community] resides if that society's values frustrate the moral purposes to which the moral community is dedicated."[4]

Physicians should be cognizant that ethics consultations have several components, including developing interventions to protect patients' rights, providing staff with moral support, and minimizing legal liability. The divergence between the latter two goals speaks to an additional component of ethics consultations: proposing solutions to conflicts.[5] *Dobbs* will make that final charge — reconciling patients' desires and clinicians' recommendations with what many perceive to be unjust and dangerous laws — challenging. But ethics committees can't easily separate the need for legal prudence from the need for moral guidance. Nor can they abandon people who seek their counsel. Instead, they should offer support to morally distressed parties and advocacy to those with the power to redress wrongs.

Finally, the *Dobbs* decision purports to advance the good of the embryo or fetus. But no one can truly value an embryo or fetus if they devalue the person carrying it, and we believe that ethics committees' counsel should reflect this fact. U.S. physicians will increasingly have to choose whether they should allow some patients to be deprived of equal rights under the law — or should demand that human rights not end when pregnancy begins.

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Accessible Weight Scales and Exam Tables — New Federal Regulations

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In early 2024, Ms. H., a retired teacher with Medicare coverage, was hospitalized for exacerbation of heart failure for the third time in 12 months. She had presented to the outpatient clinic reporting abdominal distention. As usual, she arrived in her wheelchair, which she uses because of leg weakness and spasticity. In the outpatient clinic, which only has a standing weight scale, she is rarely weighed; because of her mobility limitations and obesity, practice staff hesitate to assist her, citing liability concerns. That day, Ms. H. was not weighed, either in the outpatient clinic or once she got up to the hospital floor. Nevertheless, her admission note did list a weight, followed by the comment, "Patient reports she does not know weight. This is an estimate."

For patients with heart failure, accurate weights — especially estimated dry weight (EDW; "normal" weight without extra fluid in the

body) — are essential to inform therapeutic decisions. During her hospitalization, Ms. H.'s electronic health record noted multiple efforts to measure her weight using a scale built into her hospital bed; however, "great variability from day to day made this [bed weight] unreliable." Her body habitus complicated assessments of the volume status on physical examination. Lacking reliable weights and physical examination findings to guide treatment decisions, Ms. H.'s clinical team performed a right heart catheterization to assess her body fluid status. With the information from that procedure, the team effectively treated Ms. H. and discharged her home. Ms. H.'s discharge record states, "Of note, we are unable to get daily weights so EDW was not determined."

Although the right heart catheterization yielded critical information, this procedure carries risks, and Ms. H. said it was painful. An accessible weight scale — one that Ms. H. could roll onto and off of in her wheelchair — would have provided weight measurements to guide her care. Subjecting her to an invasive procedure for lack of accessible medical diagnostic equipment (MDE) represented poor care, reflective of the inequity of care for patients with disability. A patient with heart failure who had been able to use a standing weight scale would most likely not have undergone right heart catheterization.

For more than 50 years, disability civil rights laws in the United States have required that patients with disability receive care equivalent to that provided to patients without disability.[1] Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs receiving federal funding, such as Medicare, which covers Ms. H. Subsequent laws, including the 1990 Americans with Disabilities Act and Section 1557 of the 2010 Patient Protection and Affordable Care Act (ACA), extended equitable care mandates beyond federal programs. Nevertheless, patients with disability continue to face health care disparities, which are often caused by inaccessible MDE.[1]

Section 4203 of the ACA required that the Architectural and Transportation Barriers Compliance Board (U.S. Access Board) develop standards for accessible MDE, including weight scales and examination tables and chairs. These accessibility standards were finalized in early January 2017,[2] but ensuring that health care delivery organizations obtained and used accessible MDE required further federal rulemaking. The Trump administration halted that process in December 2017.

The Covid-19 pandemic heightened public awareness of egregious health care inequities affecting people with disability. In 2023, the Department of Health and Human Services (DHHS) proposed rules to update Section 504 regulations, addressing multiple aspects of health care, including accessible MDE. After public comments, DHHS issued final rules on May 9, 2024, that apply to all entities receiving federal funds (approximately 92% of doctors, 43% of dentists, and all hospitals).[3] Public comments from individuals and organizations, including persons with disability, advocacy groups, health care professionals, and MDE vendors, suggest that "accessible MDE is vital for health equity, person-centered care, and access to care for patients with disabilities."[3]

DHHS's Section 504 final rule incorporated the U.S. Access Board's 2017 accessibility standards[2] and states that "no individual with a disability shall be excluded from or denied the benefits of a program or activity of a recipient offered through MDE due to the inaccessibility of the recipient's MDE."[3] The new regulations specify a timeline for implementation: all new MDE acquired more than 60 days after May 9, 2024, must be accessible. Furthermore, within 2 years all settings using this MDE "at a minimum … must acquire one accessible exam table … and one accessible weight scale." These targets are especially important for primary care settings, where various diagnostic services are performed; 2 years is a "sufficient period for most recipients to budget for and acquire accessible exam tables and weight scales." Recognizing the urgency of making care accessible, DHHS denied requests for a prolonged phase-in period, extensions for small health care practices, and requiring only newly purchased equipment to be accessible. In facilities with multiple departments, clinics, or specialties in one location, DHHS recommends that accessible MDE be acquired for each individual setting or, if equipment is shared, that facility directors ensure that all patients who need this equipment will have timely access, with sensitivity to practical concerns (e.g., protecting patients' privacy if they are undressed or partially dressed when moved to another location to use accessible MDE).

The regulations also require that each clinic or department "ensure its staff is able to successfully operate accessible MDE, assist with transfers and positioning of individuals with disabilities, and carry out program access obligations for existing MDE." Ms. H.'s outpatient clinic told her to bring

her husband to help with positioning her on the standing weight scale. The regulations stipulate that a practice "cannot require a patient with a disability to bring someone along with them to help during an exam."[3] The medical practice is responsible for providing its staff with appropriate training in operating accessible MDE, and liability considerations cannot prevent provision of equitable care to patients with disability.

Most notably, the new rule specifies enforcement procedures and mandates periodic compliance reviews. This proactive stance responded to public concerns that "without 'teeth,' the regulation is not useful and will have no effect."[3] In addition to the standard periodic compliance reviews, consumers can file complaints within 180 days after allegedly experiencing discrimination, triggering an expedited process. DHHS aims for prompt investigations and cooperative, rather than punitive, efforts to resolve concerns.

Physicians often question the potential costs of disability accommodations, citing expense as a barrier to providing equitable care.[1] A Department of Justice Regulatory Impact Assessment (RIA; cost–benefit analysis) found that a standard exam table costs $1,875, as compared with $3,375 for an accessible exam table (price differential, $1,500 per unit), and a standard weight scale costs $1,467, as compared with $2,056 for an accessible weight scale (differential, $589 per unit).[4] A separate DHHS RIA of the accessible-MDE provision found — largely because of difficulties in quantifying anticipated benefits (e.g., improved health outcomes, decreased disability discrimination) — that the overall benefits in financial terms do not exceed costs (in 2022 dollars). For oncology care, however, the DHHS RIA found that accessible MDE could yield potential benefits of $145.5 million per year (range, $97.0 million to $193.9 million) by eliminating delays in cancer diagnosis and treatment. Using accessible mammography machines as a test case, the RIA estimated that anticipated benefits from this equipment alone could reach $290.9 million per year within 5 years after implementation.[5]

Requiring accessible MDE in all health care delivery settings is long overdue. Accessible MDE could mitigate health care disparities affecting people with disability, improving the quality of their care and their health outcomes. DHHS's new Section 504 MDE regulations thus strengthen civil rights protections for Americans with disability, increasing their likelihood of receiving equitable care.

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Ensuring a Safe and Sufficient Global Blood Supply

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A safe and sustainable blood supply remains elusive for many low- and middle-income countries (LMICs). The World Health Organization (WHO) considers blood and blood components to be essential medicines, which underscores their importance to health systems. Essential medicines are products that are deemed to be necessary to meet the health care needs of the majority of the population and therefore must be in adequate supply, accessible, and affordable, with their quality assured. Yet nearly two thirds of countries — including countries in central, eastern, and western sub-Saharan Africa, Oceania, and South Asia — lack sufficient blood to meet clinical demand.[1]

There are substantial disparities in the availability and safety