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Racism, Health Equity, and Crisis Standards of Care in the COVID-19 Pandemic

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RACISM, HEALTH EQUITY, AND CRISIS STANDARDS OF CARE IN THE COVID-19 PANDEMIC

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ABSTRACT

Long-standing and deeply embedded institutional racism, notably anti-Black racism in U.S. health care, has provided a solid footing for the health inequities by race evident in the COVID-19 pandemic. Inequities in susceptibility, exposure, infection, hospitalization, and treatment reflect and reinforce this racism and cause incalculable and preventable suffering in and loss of Black lives. This Article identifies multiple expressions of racism evident in the crisis standards of care (CSC) created by states and health care institutions to guide the ethical allocation of scarce critical care resources including ventilators. Contextualized within the broad landscape of health inequities pre-COVID-19 as well as during the pandemic, this Article analyzes two manifestations of racism in CSC: 1) the scarce participation of Black health care and public health professionals as well as Black communities in CSC creation, and 2) the ostensible "objectivity" and "race irrelevancy" of features of CSC. This ethical analysis leads to a proposal for dismantling racism in CSC by embracing antiracism as health equity at the outset of CSC policy-making. An initial exploration of the nature of health equity and related policies and practices in this COVID-19 era support a concluding outline of distinctive "first steps" toward antiracist pro-health equity CSC.

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I. INTRODUCTION

In late July 2020, in the midst of the COVID-19 pandemic, Trinity Health announced its plans to close Mercy Hospital, located in a predominantly Black neighborhood on the south side of Chicago.[1] The city's oldest hospital, Mercy is a "safety net hospital" serving as "an oasis in the medical desert of the predominately Black and [B]rown South Side."[2] According to Mercy's 2019 community health needs assessment, sixty-two percent of Black Chicagoans live within Mercy's service area.[3] Low health care access has been associated with high COVID-19 mortality in Chicago, a city where Black residents are at greatest risk of COVID-19 death.[4] Community activists, residents, elected officials, and clinicians argued that Mercy's closing would limit access to health care and worsen health inequities in their community.[5] In mid-December, a state review board unanimously rejected the closure plan,[6] yet since then Trinity Health has reaffirmed its intention to close the hospital.[7]

"This is what institutional racism looks like," observes *Chicago Sun-Times* columnist Mary Mitchell, "the health care system is structured in such a way that Black and Brown people do not receive the same quality care as [W]hite

1. Eric Lutz, *'People Will Die': Chicago Could Lose an Essential Hospital in the Middle of the Pandemic*, THE GUARDIAN (Dec. 13, 2020, 3:00 AM), https://www.theguardian.com/us-news/2020/dec/13/chicago-mercy-hospital-closure-covid-19.

2. *Id.*

3. DEIRDRE WATTS ET AL., COMMUNITY HEALTH NEEDS ASSESSMENT: FOR CHICAGO AND SUBURBAN COOK COUNTY, app. A (2019); Jordan Rau & Emmarie Huetteman, *Some Urban Hospitals Face Closure or Cutbacks as the Pandemic Adds to Fiscal Woes*, NPR (Sept. 15, 2020, 5:00 AM), https://www.npr.org/sections/health-shots/2020/09/15/912866179/some-urban-hospitals-face-closure-or-cutbacks-as-the-pandemic-adds-to-fiscal-woe.

4. Molly Scannell Bryan et al., *Coronavirus Disease 2019 (COVID-19) Mortality and Neighborhood Characteristics in Chicago*, 56 ANNALS EPIDEMIOLOGY 47, 51–52 (2021).

5. Lutz, *supra* note 1; Lamont J. Robinson, *The Middle of a Pandemic Is No Time to Close Mercy Hospital on Chicago's South Side*, CHI. SUN TIMES (Dec. 9, 2020, 5:15 PM), https://chicago.suntimes.com/2020/12/9/22166438/mercy-hospital-south-side-chicago-health-care-desert-closing-j-b-pritzker. *See also* Rau & Huetteman, *supra* note 3 (noting that Mercy is not the only recent hospital closure in Chicago; three other hospitals have closed in the Chicago area over the last year and they have all been in Black neighborhoods).

6. Eric Lutz, *Illinois Board Rejects Plans to Close Essential South Side Chicago Hospital*, THE GUARDIAN (Dec. 15, 2020, 7:05 PM), https://www.theguardian.com/us-news/2020/dec/15/chicago-mercy-hospital-safety-net-south-side-closure.

7. Megan Hickey, *Despite Order from State Board, Mercy Hospital & Medical Center Says It's Still Planning to Close*, CBS CHI. (Dec. 23, 2020, 6:19 PM), https://chicago.cbslocal.com/2020/12/23/despite-order-from-state-board-mercy-hospital-medical-center-says-its-still-planning-to-close/; Erin Schumaker, *What's at Stake If Mercy Hospital, Chicago's Oldest, Closes*, ABC NEWS (Dec. 20, 2020, 9:40 AM), https://abcnews.go.com/Health/stake-chicagos-oldest-hospital-closes/story?id=74757394.

people do."[8] The closure of Mercy hospital will disproportionately limit access to health care for Black residents and communities and ultimately impair their health status.[9] This Article centers its analysis of racism and health inequities in the COVID-19 pandemic on Black persons and Black communities throughout the United States; an analysis that may also be relevant to Latino, Indigenous, and Asian people who experience racism and health inequities.[10]

Nearly one in every seven persons in the United States (13.4%) identify as Black or African American, which the U.S. Census defines as, "[a] person having origins in any of the Black racial groups of Africa."[11] Black people were enslaved for 250 years, separate and unequal for 100 years, and disproportionately harmed by the 2008 to 2012 Great Recession, thus entrenching the racism that has heightened the devastating harm of the COVID-19 pandemic.[12]

Racism is a complex array of social structures, institutional practices, interpersonal interactions, and beliefs used by the dominant racial group to create a hierarchy that categorizes people into "races," and which is the basis for disempowering, devaluing, and differentially allocating societal resources to other racial groups.[13] Racism in health care is often portrayed as interpersonal, that is, individual racism that harms individuals, but racism also takes institutional forms that harm whole communities and groups.[14]

8. Mary Mitchell, *Closing Mercy Hospital a Backward Step in Quest to End Racial Disparities*, CHI. SUN TIMES (Dec. 11, 2020, 9:23 PM), https://chicago.suntimes.com/columnists/2020/12/11/22170677/trinity-health-closing-mercy-hospital-racial-disparity-health-care.

9. Rau & Huetteman, *supra* note 3.

10. We use the term health inequities to denote health disparities specifically related to racism in contrast to health inequities that have caused other factors including socioeconomic status, *see* PAULA BRAVEMAN ET AL., WHAT IS HEALTH EQUITY? AND WHAT DIFFERENCE DOES A DEFINITION MAKE? 2 (2017).

11. *About*, U.S. CENSUS BUREAU, https://www.census.gov/topics/population/race/about.html (last updated Oct. 16, 2020); *Quick Facts: United* States, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/PST045219 (last visited Jan. 29, 2021).

12. Leonard E. Egede & Rebekah J. Walker, *Structural Racism, Social Risk Factors, and Covid-19 – A Dangerous Convergence for Black Americans*, NEW ENG. J MED., Sept. 17, 2020, at e77(1), e77(1); Christopher Famighetti & Darrick Hamilton, *The Great Recession, Education, Race, and Homeownership*, ECON. POL'Y INST. (May 15, 2019, 2:04 PM), https://www.epi.org/blog/the-great-recession-education-race-and-homeownership/.

13. JOE R. FEAGIN, SYSTEMIC RACISM: A THEORY OF OPPRESSION 25 (2006); David R. Williams et al., *Racism and Health: Evidence and Needed Research,* 40 ANN. REV. PUB. HEALTH 105, 106 (2019); Zinzi Bailey et al., *How Structural Racism Works – Racist Policies as a Root Cause of U.S. Racial Health Disparities*, NEW ENG. J. MED., Dec. 16, 2020, at 1.

14. Williams et al., *supra* note 13; FEAGIN, *supra* note 13, at 23; Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 U. CONN. L. REV. 1281, 1308 (2012); Ruqaiijah Yearby & Seema Mohapatra, *Law, Racism and the COVID-19 Pandemic*, 7 J.L. & BIOSCIENCES, May 30, 2020, at 3; Courtney D. Cogburn, *Culture, Race, and Health: Implications for Racial Inequities and Population Health*, 97 MILBANK Q. 736, 738 (2019); Kira Hudson Banks & Jadah Stephens,

Institutional racism "refers to the processes of racism that are embedded in laws (local, state, and federal), policies, and practices of society and its institutions that provide advantages to racial groups deemed as superior," while limiting the power and "differentially oppressing, disadvantaging, or otherwise neglecting racial groups viewed as inferior."[15] One example of institutional racism is racial residential segregation.[16] As a result of racist mortgage lending and other practices,[17] Blacks have been relegated to racially segregated neighborhoods that lack access to healthy food,[18] clean air,[19] and safe places to exercise.[20] This has been associated with Black people's higher rates of chronic diseases such as blood disorders (sickle cell and diabetes), kidney disease, obesity, and heart disease.[21] These chronic diseases not only decrease Black

Reframing Internalized Racial Oppression and Charting a Way Forward, 12 SOC. ISSUES POL'Y REV. 91, 93 (2018); Leith Mullings & Amy J. Schulz, *Intersectionality and Health: An Introduction*, *in* GENDER, RACE, CLASS, AND HEALTH: INTERSECTIONAL APPROACHES 3, 12 (Amy J. Schulz & Leith Mullings eds. 2006).

15. Williams et al., *supra* note 13, at 107. *See* Ruqaiijah Yearby, *Reifying Racism in the COVID-19 Pandemic Response*, 21 AM J. BIOETHICS 75, 76 (2021); *see also* Jeffrey T. Berger & Dana Ribeiro Miller, *Corona and Community: The Entrenchment of Structural Bias in Planning for Pandemic Preparedness*, 20 AM. J. BIOETHICS 112, 112 (2020).

16. Williams et al., *supra* note 13, at 107; FEAGIN, *supra* note 13, at 23; Yearby, *supra* note 14, at 1285–86; Yearby & Mohapatra, *supra* note 14, at 7.

17. Dylan Scott, *Housing Segregation Left Black Americans More Vulnerable to COVID-19*, VOX (July 10, 2020, 4:38 PM), https://www.vox.com/2020/7/10/21319873/covid-19-coronavirus-cases-deaths-black-americans-housing-segregation; RICHARD ROTHSTEIN, THE COLOR OF LAW 50–51, 148 (2017).

18. Melody Goodman et al., *How Segregation Makes Us Fat: Food Behaviors and Food Environment as Mediators of the Relationship Between Residential Segregation and Individual Body Index*, FRONTIERS PUB. HEALTH, Mar. 2018, at 1, 10.

19. Bongki Woo et al., *Residential Segregation and Racial/Ethnic Disparities in Ambient Air Pollution*, 11 RACE & SOC. PROBS. 60, 64 (2019).

20. Penny Gordon-Larsen et al*., Inequality in the Built Environment Underlies Key Health Disparities in Physical Activity and Obesity*, 117 PEDIATRICS 417, 422 (2006).

21. DEP'T OF HEALTH & HUM. SERVS., HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH 12 (2000); Tmirah Haselkorn et al., *Racial Disparities in Asthma-Related Health Outcomes in Severe or Difficult-to-Treat Asthma*, 101 ANNALS ALLERGY, ASTHMA & IMMUNOLOGY 256, 260 (2008); Sonja S. Hutchins et al., *Protection of Racial/Ethnic Minority Populations During an Influenza Pandemic*, 99 AM. J. PUB. HEALTH S261, S263 (2009); Anthony P. Polednak, *Racial Differences in Mortality from Obesity-Related Chronic Diseases in US Women Diagnosed with Breast Cancer*, 14 ETHNICITY & DISEASE 463, 465 tbl.1 (2004); *Heart Disease and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=19 (last visited Feb. 1, 2021).

people's life expectancy compared to Whites,[22] but also it makes them more susceptible to viruses, such as COVID-19.[23]

In a 2012 report regarding health equity and pandemics, the U.S. Department of Health and Human Services (HHS) acknowledged that inequities in infections and deaths during pandemics were due to racism that increased Black people's susceptibility to infections and decreased Black people's access to health care.[24] However, HHS's proposed solutions for this issue did not address eliminating racism. Even though the recommendations discussed establishing partnerships between community representatives and the public health preparedness system, they did not empower communities to take the lead in developing strategies to address to pandemics.[25] This has been replicated during the COVID-19 pandemic, as officials work to develop partnerships to educate communities about the virus, but fail to empower communities to develop strategies to fight the spread of COVID-19.[26] Making matters worse, some federal public health officials and state government officials have begun to blame racial and ethnic minorities for inequities related to COVID-19.[27]

22. Sofia Carratala & Connor Maxwell, *Health Disparities by Race and Ethnicity*, CTR. FOR AM. PROGRESS (May 7, 2020, 9:04 AM), https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/. *See* Robert T. Carter et al., *A Meta-Analytic Review of Racial Discrimination: Relationships to Health and Culture*, 11 RACE & SOC. PROBS. 15, 20 (2019).

23. Yearby & Mohapatra, *supra* note 14, at 2. *See COVID-19: People with Certain Medical Conditions*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last updated May 13, 2021); Sandra Crouse Quinn et al., *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, 101 AM. J. PUB. HEALTH 285, 285–86 (2011); *see also* Monica Schoch-Spana et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies*, 8 BIOSECURITY & BIOTERRORISM 243, 244 fig.1 (2010); Philip Blumenshine et al., *Pandemic Influenza Planning in the United States from a Health Disparities Perspective*, 14 EMERGING INFECTIOUS DISEASES 709, 711 tbl. (2008).

24. DENNIS P. ANDRULIS ET AL., OFF. MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUM. SERVS., H1N1 INFLUENZA PANDEMIC AND RACIALLY AND ETHNICALLY DIVERSE COMMUNITIES IN THE UNITED STATES 5, 23 (2012).

25. *See id.* at 25 (calling for funds "to develop and sustain activities that strengthen diverse communities' ability to prepare, respond to, and recover from emergency events," but fails to provide funding for communities to develop their own plans to address emergency events. As discussed in Part IV, communities should lead the development of the plan to respond to pandemics so that the plan includes their values and addresses their needs.).

26. *See HHS Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities*, DEP'T OF HEALTH & HUM. SERVS. 1, 2, 4, https://www.hhs.gov/sites/default/files/hhs-fact-sheet-addressing-disparities-in-covid-19-impact-on-minorities.pdf (last visited May 28, 2021).

27. *E.g.*, Trip Gabriel, *Ohio Lawmaker Asks Racist Question About Black People and Hand-Washing*, N.Y. TIMES (June 11, 2020), https://www.nytimes.com/2020/06/11/us/politics/steve-huffman-african-americans-coronavirus.html; Sarah Westwood & Sunlen Serfaty, *HHS Secretary*

Ohio State Senator and physician, Stephen A. Huffman, charged with enacting laws to protect citizens from the spread of COVID-19 and treating COVID-19 patients, speculated "could it just be that African-Americans or the colored population do not wash their hands as well as other groups or wear a mask or do not socially distance themselves?"[28] When asked about the inequities in COVID-19 infections and deaths during a White House COVID-19 briefing, Surgeon General Jerome Adams, a Black physician, noted that the inequities were not biological or genetic, but stated that people of color should "avoid alcohol, tobacco and drugs" to prevent the spread of COVID-19. We need you to step up and stop the spread so that we can protect those who are most vulnerable."[29] By blaming Black persons for health inequities in COVID-19 infections and deaths, these government officials reinforced the notion that Black people behave in unhealthy ways, thus making Black persons responsible not only for their own COVID-19 infections but for the infections of others. Additionally, these officials ignored their duties to create policies that not only substantially engage these communities, which help assure that all persons are equitably cared for, but also disregarded their duty to effectively address racism. An example of these failures is Crisis Standards of Care (CSC).

CSC are ethical and clinical guidelines created to achieve the fair allocation of scarce critical care resources to seriously ill patients during public health emergencies.[30] The COVID-19 pandemic has prompted the creation or revision of CSC by many state health departments and health care institutions.[31] Although racial and ethnic minority communities have been disproportionately impacted by COVID-19, they have been marginalized in the processes of CSC

Tells Lawmakers Lifestyles of Meat-Processing Plant Employees Worsened Covid-19 Outbreak, CNN (May 7, 2020, 4:58 PM), https://www.cnn.com/2020/05/07/politics/alex-azar-meat-processing-plants/index.html; Carmen Sesin, *Latino Leaders Demand Florida Governor Apologize for Linking 'Hispanic Farmworkers' to COVID-19 Rise*, NBC NEWS (June 22, 2020, 10:23 PM), https://www.nbcnews.com/news/latino/latino-leaders-demand-gov-desantis-apologize-linking-hispanic-farmworkers-covid-n1231785; Brett Murphy & Letitia Stein, *Feds Explore Whether Latino Immigrants to Blame for Coronavirus Flare-Ups*, USA TODAY (June 18, 2020, 7:18 PM), https://www.usatoday.com/story/news/investigations/2020/06/18/coronavirus-flare-ups-raise-task-force-questions-immigration/3210219001/.

28. Gabriel, *supra* note 27.

29. Curtis Bunn, *Black Health Experts Say Surgeon General's Comments Reflect Lack of Awareness of Black Community*, NBC NEWS (Apr. 15, 2020, 2:41 PM), https://www.nbcnews.com/news/nbcblk/black-health-experts-say-surgeon-general-s-comments-reflect-lack-n1183711.

30. AM. NURSES ASS'N, CRISIS STANDARDS OF CARE COVID-19 PANDEMIC (2020).

31. Emily C. Cleveland Manchanda et al., *Crisis Standards of Care in the USA: A Systemic Review and Implications for Equity Amidst COVID-19*, J. RACIAL & ETHNIC HEALTH DISPARITIES, Aug. 2020, https://link.springer.com/article/10.1007/s40615-020-00840-5.

creation.[32] Furthermore, the ostensibly objective triage protocols of most CSC, in effect, prioritize White people's lives above those of Black people.[33]

Ibram Kendi's work on antiracism[34] is helpful for envisioning antiracism as health equity wherein "everyone has the opportunity to attain full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance."[35] Antiracism "is a powerful collection of antiracist policies that lead to racial equity and are substantiated by antiracist ideas."[36] The powerful multi-sector resistance to the attempted closure of Chicago's Mercy Hospital reflects an antiracist commitment to equitable health for Black and other local communities. We assert that the state-level governments and health care institutions drafting and implementing CSC should adopt an antiracist approach with the aim of achieving health equity. This approach would, among other things, require health leaders to partner with Black communities in drafting the CSC and to prioritize health equity when determining how care will be allocated. Here, we focus on the racism within CSC, fully cognizant that achieving health equity will require addressing the many and broader manifestations of racism in the U.S. health care and public health systems. This particular policy analysis may well be relevant for analyzing racism in other health policies, including, most immediately, vaccine allocation, and in the longer term, policies in non-pandemic contexts.

This Article proceeds as follows: Part II discusses how racism has caused health inequities before and during the COVID-19 era. Part III examines how racism in CSC reinforces racial hierarchy through "objectivity" and "race irrelevant" practices, which, if implemented, will result in reduced critical care resources and harms to the health of Black people. Part IV suggests the integration of antiracist ideas and practices into CSC to achieve health equity.

II. RACISM, HEALTH INEQUITIES, AND COVID-19

Racism takes many forms but essentially is a social system wherein the racial group in power creates a racial hierarchy that deems other racial groups to be inferior and grants those "races" disproportionately fewer resources and opportunities.[37] In the United States, this racial hierarchy[38] is embedded in

32. *Id.*

33. *Id.*

34. *See generally* IBRAM X. KENDI, HOW TO BE AN ANTIRACIST (2019).

35. *Health Equity*, CTRS. FOR DISEASE CONTROL & PREVENTION (2020), https://www.cdc.gov/chronicdisease/healthequity/index.htm.

36. KENDI, *supra* note 34, at 20.

37. FEAGIN, *supra* note 13, at 42, 261, 273; Williams et al., *supra* note 13, at 106; Yearby, *supra* note 14, at 1302.

38. Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOCIO. REV. 465, 474 (1997).

institutional practices including laws, policies, and social norms that cause health inequities and prevent Black people's attainment of health equity.[39] Racial residential segregation is one example of institutional racist practices.[40]

Residential segregation in the United States is linked to racist mortgage lending and zoning practices and has been associated with higher rates of chronic disease for Blacks, which has further increased their susceptibility to COVID-19.[41] It is also linked to the closure of public urban hospitals in predominately Black neighborhoods prior to and during the COVID-19 pandemic.[42] As a result of such hospital closures, many Black people lacked access to testing and treatment during the initial COVID-19 lockdown/stay at home orders, reinforcing a racial hierarchy, wherein racial minority lives are not treated as equally important.[43]

Such institutional practices of racism are often ignored or viewed as irrelevant, especially in health law, public health policy, and health care practice.[44] When public health and health care professionals and institutions do notice racism, they tend to emphasize interpersonal racism.[45] During the

39. BRAVEMAN ET AL., *supra* note 10, at 4–5; Berger & Miller, *supra* note 15, at 113; Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality,* 67 UCLA L. Rev. 758, 787 (2020); DANIEL DAWES, THE POLITICAL DETERMINANTS OF HEALTH 19 (2020); Sidney Watson, *Lessons from Ferguson and Beyond: Bias, Health, and Justice*, 18 MINN. J.L. SCI. & TECH. 111, 115 (2017); DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 138 (2015); René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 81, 98 (2001).

40. BRAVEMAN ET AL., *supra* note 10, at 5.

41. Scott, *supra* note 17.

42. Michelle Ko et al., *Residential Segregation and the Survival of U.S. Urban Public Hospitals*, 71 MED. CARE RSCH. & REV. 243, 247 (2014).

43. Yearby & Mohapatra, *supra* note 14, at 13, 15.

44. William C. Jenkins, *Foreword: The Long Trajectory*, *in* RACISM: SCIENCE & TOOLS FOR THE PUBLIC HEALTH PROFESSIONAL xxi, xxi (Maya Ribault, ed., 2020); Keon Gilbert et al., *Visible and Invisible Trends in Black Men's Health: Pitfalls and Promises for Addressing Racial, Ethnic, and Gender Inequities in Health*, 37 ANN. REV. PUB. HEALTH 295, 300 (2016).

45. *See* Yearby, *supra* note 14, at 1320; Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 492 (2012); Janice Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 898, 907 (2009) ("Experiences of discrimination in health care lead to delay in seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the health care system."); James Collins, Jr. et al., *Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination*, 94 AM. J. PUB. HEALTH 2132, 2133, 2137 (2004) (discussing study results and finding that interpersonal racial discrimination experiences have an effect on pregnancy outcomes of African American women); Michelle Van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perception of Patients*, 50 SOC. SCI. & MED. 813, 813–14 (2000) ("Physicians' perceptions of patients may vary by patient race, socio-economic status, or other demographic characteristics . . . . [T]hese differences in perceptions may

COVID-19 pandemic, this has been evidenced by the focus on denials of care experienced by Black patients, rather than on institutional decisions, such as hospital closures and the failure to release race-specific COVID-19 data needed for contact tracing.[46] Thus, health law, public health, and health care professionals and institutions legitimize the system of racism by either asserting that race is irrelevant to institutional practices or rarely questioning the existing social structures, institutional practices, relationships, or beliefs that limit Black people's equal access to health care.[47]

Part II.A discusses how institutional racism is linked to health inequities, while Part II.B examines the negative impact institutional racism has had, and continues to have, on the COVID-19 pandemic response. Institutional racism that results in Black people's higher rates of chronic disease, increased susceptibility to COVID-19, and lack of access to hospital care has also been ignored in discussions about the allocation of critical care resources, which is discussed in Part III.

A. Racism and Health Inequities

Overall, residential segregation has decreased in the United States, but as of 2010, some cities like St. Louis City, Missouri, and Boston, Massachusetts, remain segregated.[48] Residential segregation is associated with increased

explain some of the variance in physician behavior toward and treatment of patients."); Neil S. Calman, *Out of the Shadow*, 19 HEALTH AFFS. 170, 172–73 (2000) (describing the main types of prejudice in health professionals and exploring how they impact and limit patients' health care opportunities); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catherization*, 340 NEW ENG. J. OF MED. 618, 623 (1999) ("We found that the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catherization, even after we adjusted for symptoms, the physicians' estimates of the probability of coronary disease, and clinical characteristics."); SEC'YS TASK FORCE ON BLACK & MINORITY HEALTH, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH 10 (1989).

46. Arielle Mitropoulos & Mariya Moseley, *Beloved Brooklyn Teacher, 30, Dies Of Coronavirus After She Was Twice Denied a COVID-19 Test*, ABC NEWS (Apr. 28, 2020, 7:39 PM), https://abcnews.go.com/Health/beloved-brooklyn-teacher-30-dies-coronavirus-denied-covid/story?id=70376445; Shamar Walters & David K. Li, *New York City Teacher Dies from Covid-19 After She Was Denied Tests, Family Says*, NBC NEWS (Apr. 29, 2020, 4:42 PM) https://www.nbcnews.com/news/us-news/new-york-city-teacher-dies-covid-19-after-she-was-n1195516; *Detroit Man with Virus Symptoms Dies After 3 ERs Turn Him Away, Family Says: "He Was Begging For His Life"*, CBS NEWS (Apr. 22, 2020, 8:10 AM), https://www.cbsnews.com/news/coronavirus-detroit-man-dead-turned-away-from-er/ [hereinafter *Detroit Man Dies*]; Robert Samuels et al., *"This Is What Happens to Us." How U.S. Cities Lost Precious Time to Protect Black Residents from the Coronavirus*, WASH. POST (June 3, 2020), https://www.washingtonpost.com/graphics/2020/politics/coronavirus-race-african-americans/.

47. Samuels et al., *supra* note 46. *See also* Yearby, *supra* note 14, at 1323.

48. Douglas S. Massey & Jonathan Tannen, *A Research Note on Trends in Black Hypersegregation*, 52 DEMOGRAPHY 1025, 1031 (2015). In fact, St. Louis City and Boston, MA

mortality and has been shown to limit Black people's opportunities to be healthy.[49] In particular, Black neighborhoods that are racially segregated usually have less economic investment[50] and thus have fewer resources such as healthy food[51] and places to exercise or play.[52] Indeed, residents in predominately Black neighborhoods "do not have access to healthy food due to a lack of supermarkets and a preponderance of convenience stores and fast food restaurants as the primary food outlets."[53] Such limited access to healthy food options has been shown to lead to obesity, a risk factor for cancer, cardiovascular disease,[54] and COVID-19.[55] Residential segregation has also been linked to Black persons' higher rates of heart disease and stroke[56] and blood pressure,[57] as well as

remain hypersegregated, which means they have at least four of the five dimensions of segregation: "[*u*]*nevenness* is the degree to which blacks and whites are unevenly distributed across neighborhoods in a metropolitan area; *isolation* is the extent to which African Americans live in predominantly black neighborhoods; *clustering* is the degree to which neighborhoods inhabited by African Americans are clustered together in space; *concentration* is the relative amount of physical space occupied by African Americans within a given metropolitan environment; and *centralization* is the degree to which blacks reside near the center of a metropolitan area." *id.* at 1027.

49. Williams et al., *supra* note 13, at 107; Keon Gilbert et al., *Racial Composition Over the Life Course: Examining Separate and Unequal Environments and the Risk for Heart Disease for African American Men*, 25 ETHNICITY & DISEASE 295, 296 (2015); Tse-Chuan Yang & Stephen A. Matthews, *Death by Segregation: Does the Dimension of Racial Segregation Matter?*, PLOS ONE, Sept. 2015, at 19; Michael R. Kramer & Carol Hogue, *Is Segregation Bad for Your Health?*, 31 EPIDEMIOLOGIC REV. 178, 183 (2009); Roland Thorpe et al., *Social Context as an Explanation for Race Disparities in Hypertension: Findings from the Exploring Health Disparities in Integrated Communities (EHDIC) Study*, 67 SOC. SCI. & MED. 1604, 1605 (2008); Antwan Jones, *Segregation and Cardiovascular Illness: The Role of Individual and Metropolitan Socioeconomic Status*, 22 HEALTH & PLACE 56, 56 (2013).

50. Renee E. Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876, 876 (2010).

51. *Id.*; Goodman et al., *supra* note 18.

52. Gordon-Larsen et al., *supra* note 20.

53. Martha E. Lang & Chloe E. Bird, *Understanding and Addressing the Common Roots of Racial Disparities: The Case of Cardiovascular Disease & HIV/AIDS in African Americans*, 25 HEALTH MATRIX 109, 131 (2014).

54. Walker et al., *supra* note 50, at 878; Nicole I. Larson et al., *Neighborhood Environments: Disparities in Access to Healthy Foods in the US*, 36 AM. J. PREV. MED. 74–81 (2009); Lavonna Blair Lewis et al., *African Americans' Access to Healthy Food Options in South Los Angeles Restaurants*, 95 AM. J. PUB. HEALTH 668, 672 (2005).

55. *See Obesity, Race/Ethnicity, and COVID-19*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/obesity/data/obesity-and-covid-19.html (last visited Jan. 25, 2021).

56. Sophia Greer et al., *Racial Residential Segregation and Cardiovascular Mortality: Exploring Pathways*, 91 J. URB. HEALTH 499, 500 (2014).

57. Kiarri Kershaw et al., *Association of Changes in Neighborhood-Level Racial Residential Segregation with Changes in Blood Pressure Among Black Adults: The CARRDIA Study*, 177 JAMA INTERNAL MED. 996, 997, 1001 (2017).

increased air pollution,[58] all of which are risk factors for COVID-19.[59] Racial segregation also affects where Black people receive health care.

In racially segregated neighborhoods, Blacks are disproportionately likely to undergo surgery in low quality hospitals, whereas in areas with low degrees of racial segregation, Blacks and Whites are likely to undergo surgery at low quality hospitals at the same rate.[60] This is significant because among Medicare patients, most of the inequities in risk-adjusted death rates for major surgery are a result of the site of care.[61] Additionally, since 1937, hospital placement, closures, and removal of services has been linked to race.[62] The situation at Chicago's Mercy Hospital is only one of the latest in a long-standing pattern of closures in Black neighborhoods. In 2006, Alan Sager reported that as the Black population in a neighborhood increased, the closure and relocation of hospital services also increased for every period between 1980 to 2003, except between 1990 and 1997.[63]

In fact, Sager showed that forty-five percent of hospitals open in 1970 had closed by 2010, and of these hospitals, sixty percent were in neighborhoods that were predominately Black.[64] St. Louis and Detroit are poignant examples of locations with these race-based hospital closures. In the 1970s, St. Louis had eighteen hospitals in predominately Black neighborhoods.[65] By 2010, all but one had closed.[66] In 1960, Detroit had forty-two hospitals open in predominately Black neighborhoods; by 2010, only four were open.[67] Current research shows

58. Woo et al., *supra* note 19; Morgan Grove et al., *The Legacy Effect: Understanding How Segregation and Environmental Injustice Unfold over Time in Baltimore*, 108 ANNALS AM. ASS'N GEOGRAPHERS 524, 525 (2018).

59. *People with Certain Medical Conditions*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last updated Dec. 29, 2020).

60. Justin Dimick et al., *Black Patients More Likely than Whites to Undergo Surgery at Low-Quality Hospitals in Segregated Regions*, 32 HEALTH AFFS. 1046, 1050 (2013).

61. *Id.*

62. ALAN SAGER & DEBORAH SOCOLAR, HEALTH REFORM PROGRAM, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 27 (2006).

63. *Id.* at 42.

64. Alan Sager, Professor of Health Pol'y and Mgmt. at Bos. Univ. Sch. of Pub. Health, Presentation at Law-Medicine Symposium, Case Western Reserve University School of Law: Urban Hospital Closings: Why Care? What to Do? Policy and Financial Remedies for a Race-linked Health Problem 28 (Mar. 28, 2014) (presentation on file with the author) [hereinafter Sager Presentation]. *See also* Alan Sager, *Urban Hospital Closings in the Face of Racial Change*, 5 HEALTH L. PROJECT LIBR. BULL. 169, 170 (1980) [hereinafter *Urban Hospital Closings*].

65. *See* Sager Presentation, *supra* note 64, at 3; Tim O'Neil, *A Groundbreaking Moment Creates a Showcase Hospital for Black St. Louisans*, ST. LOUIS POST-DISPATCH (Dec. 10, 2020), https://www.stltoday.com/news/local/history/a-groundbreaking-moment-creates-a-showcase-hospital-for-black-st-louisans/article_568cf3c9-533a-5fc2-8067-6537ea5cf9d3.html.

66. O'Neil, *supra* note 65.

67. *See* Sager Presentation, *supra* note 64, at 31.

that residential segregation was associated with urban public hospital closures from 1987 to 2007 in the United States.[68] In the Jim Crow era, these hospital closures were overtly linked to race.[69] Since the passage of Title VI of the Civil Rights Act of 1964, hospitals have justified closures and relocations based on financial concerns, without considering the harmful impact on Black communities.[70] In order to control costs, state and federal regulators have allowed hospitals to make this decision without seriously considering or balancing the needs of Black communities.[71]

For example, citing financial concerns, numerous public hospitals have recently closed in major urban areas, serving predominately poor and predominately Black neighborhoods, including in Philadelphia, Milwaukee, metropolitan Chicago, the San Francisco Bay area, and Washington, D.C.[72] However, many of the parent companies of the hospitals have reported profits. For example, in 2019, Providence Hospital in Washington, D.C., was closed after 158 years because of financial concerns, yet the owners, Ascension Health "posted $2.3 billion dollars in net income in 2018, (and) Ascension CEO Anthony Tersigni earned nearly $14 million according to 2015 tax records."[73] The loss of the hospital, which served largely poor, elderly, and Black populations, left its patients with limited access to hospital care.[74] Since the closures, predominately Black communities have not gained access to hospitals.[75] Moreover, the closures often exacerbate physician shortages and further overburden emergency rooms, leaving Blacks humiliated, frustrated, and feeling helpless.[76] Consequently, most predominately White neighborhoods have access to many health care services, while many Black neighborhoods are

68. Michelle Ko et al., *Residential Segregation and the Survival of US Urban Public Hospitals*, 71 MED. RSCH. & REV. 247, 249 (2014).

69. *See The Jim Crow Era*, AM. BATTLEFIELD TRUST, https://www.battlefields.org/learn/articles/jim-crow-era (last visited Jan. 28, 2021) (stating that racial discrimination during the Jim Crow era lasted until 1965); *see also* Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTHCARE L. 1023, 1030 (2005) (discussing research that establishes correlations between race and hospital closures between 1937–1980).

70. Clark, *supra* note 69, at 1031, 1040 (stating that the increased travel time and distance to medical health care facilities is often a matter of "the difference between life and death" in minority communities, especially given the extraordinarily high rates of violent crimes in such areas).

71. *Id.* at 1073 (stating that local governments often relocate hospitals on a fiscal basis, thus leading to a greater loss of hospital services among minority communities that generally have a higher need for medical services).

72. Joseph P. Williams, *Code Red: The Grim State of Urban Hospitals*, U.S. NEWS (July 10, 2019), https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close.

73. *Id.*

74. *Id.*

75. *Id. See also* Rau & Huetteman, *supra* note 3.

76. Clark, *supra* note 69, at 1039.

left without adequate, or in many cases without any, health care services.[77] Additionally, hospital closures have failed to control costs.

Research shows that the anticipated benefits from hospital closures rarely materialize because as hospitals decrease the number of beds available in Black communities, they simultaneously increase the number of hospital beds in predominately White communities.[78] Therefore, the number of beds stays the same overall.[79] Hence, hospital closures do not necessarily save money, and also they reinforce the racial hierarchy in health care that Black persons' health does not matter compared to the health of White persons.[80]

B. Racism and COVID-19

As discussed in Part II.A, Black people disproportionately suffer from chronic diseases, some of which are risk factors for COVID-19.[81] Thus, it is not surprising that Black people continue to be overrepresented in infections, hospitalizations, and deaths during the COVID-19 pandemic. As of July 2020, the COVID-19 infection rate for Blacks was 107 per 1000 people, compared to 46 per 1000 for Whites.[82] The COVID-19 hospitalization rate for Blacks was more than three times that of Whites, while the COVID-19 death rates of Blacks was twice that of Whites.[83] Black people's increased risk for COVID-19 is exacerbated by the lack of access to testing and treatment[84] due to institutional actions and decisions. These actions have established separate and independent barriers that prevent Black peoples' equal access to health care. One such barrier is the substandard care provided by hospitals located in predominately Black communities, even though the hospitals are making a substantial profit.

For example, Leonard Green & Partners, a private equity firm, bought control of a hospital company named Prospect Medical Holdings for $205

77. *Id.* at 1024, 1037 ("[N]ewer facilities in affluent areas will be given priority in the allocation of scarce resources. This sends a clear message to minority communities that they are less valuable and less deserving of certain resources than the white communities.").

78. *Id.* at 1033–34, 1040 (describing how physicians followed white patients who moved to the suburbs during the 1970s and 1980s).

79. *Id.* at 1035, 1040 (demonstrating the reduction of beds in minority communities, which generally have the greatest need for care, further compromises Blacks' health by decreasing their access to health care, thereby increasing health care costs).

80. *Id.* at 1029.

81. Lily Rubin-Miller et al., *COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data*, KAISER FAM. FOUND. (Sept. 16, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/.

82. *Id.*

83. *Id.* (illustrating these racial disparities in hospitalizations and deaths remain even after controlling for underlying health conditions and sociodemographic factors, such as socioeconomic status).

84. *Id.*

million and extracted $400 million by loading up the company with debt.[85] Prospect CEO Sam Lee made $128 million while building the company and a second executive with an ownership stake took home $94 million.[86] Many of Prospect's facilities are in low-income areas that have been disproportionately impacted by COVID-19.[87] In March 2020, a Prospect New Jersey hospital made national headlines for the first COVID-19 death of a United States emergency room doctor, and prior to the doctor's death, "the doctor told a friend he'd become sick after being forced to reuse a single mask for four days."[88] At a Prospect Rhode Island hospital, "a locked ward for elderly psychiatric patients had to be evacuated and sanitized after poor infection control spread COVID-19 to 19 of its 21 residents," resulting in six deaths.[89] The virus also killed the head of the housekeeping department and "sickened a half-dozen members of the housekeeping staff, which had been given limited personal protective equipment."[90]

The failure to release race specific COVID-19 data, which could be used to allocate testing and treatment resources and achieve health equity, is another obstacle that prevents Black peoples' equal access to health care. Public health officials in Nashville, Tennessee, Shreveport, Louisiana, and Jackson County, Missouri, decided to report COVID-19 data, without linking to race, to prevent Blacks from feeling inferior or being blamed for the disease.[91] Yet, by adopting this approach, public health officials lost precious time in providing resources to Black communities that were disproportionately harmed by COVID-19. In Michigan, the statewide task force did not focus on race or expand testing in predominately Black communities until late April 2020.[92] By that time Black people accounted for thirty-three percent of all COVID-19 infections and forty-one percent of the deaths, although they represent only fourteen percent of the population.[93] The predominately Black city of Gary, Indiana, finally got a mobile testing site, when the state revealed that Blacks accounted for twenty percent of all COVID-19 deaths, although they only represented ten percent of

85. Peter Elkind & Doris Burke, *Investors Extracted $400 Million from a Hospital Chain that Sometimes Couldn't Pay for Medical Supplies or Gas for Ambulances*, PROPUBLICA (Sept. 30, 2020), https://www.propublica.org/article/investors-extracted-400-million-from-a-hospital-chain-that-sometimes-couldnt-pay-for-medical-supplies-or-gas-for-ambulances.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. Elkind & Burke, *supra* note 85.

91. Samuels et al., *supra* note 46.

92. *Id.*

93. *COVID-19 Has Already Killed More Detroiters than Homicides Have in the Past Two Years*, FOX 2 DETROIT (Apr. 16, 2020), https://www.fox2detroit.com/news/covid-19-has-already-killed-more-detroiters-than-homicides-have-in-the-past-two-years-combined.

the population.[94] Yet, after two weeks, the mobile site moved to another city.[95] This inadequate testing has impacted many predominately Black cities, even as community activists and public health officials have asked local governments for access to testing and treatment to address inequities in COVID-19 infections and deaths.[96]

On April 8, 2020, all twelve deaths from COVID-19 in St. Louis City were Black people; however, Black communities did not get public testing sites until after the data was released.[97] More specifically, the "predominately Black north St. Louis got its first testing site April 2, three weeks after the first sites went up in the suburbs," and the "information campaign targeting Black residents did not start until a week after that," and at that time, all the COVID-19 deaths were Black people.[98] According to Dr. Will Ross, the chairman of the St. Louis health advisory board making decisions about the COVID-19 response, Black lives were unnecessarily lost because "race neutral" decisions by the government regarding the placement of testing sites ignored the fact that Black communities most impacted by COVID-19 lacked access to public testing sites.[99]

As of December 18, 2020, Black people accounted for thirty-two percent of all COVID-19 cases and fifty-nine percent of all deaths in St. Louis City,[100] yet public testing sites still remain scarce in many Black neighborhoods. The zip code with one of the highest rates of COVID-19 cases in St. Louis City (63113) is ninety-two percent Black[101] and lacks a public testing site for COVID-19.[102] This is significant because many people residing in this zip code are below the poverty line and lack access to a vehicle,[103] limiting their ability to travel outside their zip code for testing. It also requires them to use public transportation, which

94. Samuels et al., *supra* note 46.

95. *Id.*

96. *Id.*

97. *Id.*; MO. HOSP. ASS'N, THE DISPROPORTIONATE IMPACT OF COVID-19 ON BLACK AND AFRICAN AMERICAN COMMUNITIES IN THE ST. LOUIS REGION (2020).

98. Samuels et al., *supra* note 46.

99. *Id.*

100. *See COVID-19 Demographic Data*, CITY OF ST. LOUIS DEP'T OF HEALTH, https://www.stlouis-mo.gov/covid-19/data/demographics.cfm (last visited Jan. 23, 2021) (percentages are calculated using the data on total cases and total deaths by race from the "Cases and Deaths by Race" data table).

101. *COVID-19 Cases by ZCTA*, CITY OF ST. LOUIS DEP'T OF HEALTH, https://www.stlouis-mo.gov/covid-19/data/zip.cfm (last visited Jan. 23, 2021); *2020 Demographics – Summary Data for Zip Code: 63113*, THINK HEALTH ST. LOUIS, https://www.thinkhealthstl.org/demographicdata (click dropdown menu below "2021 Demographics" and select the zip code "63113") (last visited Jan. 23, 2020) [hereinafter *Demographics by Zip Code*].

102. *Public Testing Locations*, CITY OF ST. LOUIS DEP'T OF HEALTH, https://www.stlouis-mo.gov/covid-19/data/test-locations.cfm (last visited Jan. 23, 2021).

103. *Social Vulnerability by Zip Code*, CITY OF ST. LOUIS DEP'T OF HEALTH, https://www.stlouis-mo.gov/covid-19/data/social-vulnerability.cfm (last visited Jan. 23, 2021) (data housed under "No Vehicle"); *Demographics by Zip Code*, *supra* note 101.

increases their exposure to COVID-19. Limited access to testing facilities in some predominately Black communities has been exacerbated by the national shortage of testing supplies.[104] Yet, hospitals serving predominately White and wealthy areas were able to secure ventilators and testing materials, as well as stockpile protective equipment in St. Louis, Missouri, Merrillville, Indiana, and Nashville, Tennessee.[105] Even if Black persons are able to overcome institutional racist practices and gain access to COVID-19 testing, they may not be able to access clinically appropriate and timely treatment due to interpersonal racism, as the recent high profile death of Dr. Susan Moore illustrates.[106] Dr. Moore, a Black physician infected and hospitalized with COVID-19, posted on Facebook about her poor treatment by a White physician who disregarded her pain and suggested her (premature) discharge. In a December 4, 2020, video she said "This is how Black people get killed, when you send them home and they don't know how to fight for themselves."[107] She was re-hospitalized twelve hours after her discharge and died thirteen days later. It is in this racist health care environment that CSC are created and potentially implemented.

III. RACISM AND CRISIS STANDARDS OF CARE

The COVID-19 pandemic in the United States has prompted the creation or revision of CSC by many state health departments and health care systems/institutions. A recent systematic review of CSC found that twenty-nine states have created CSC; twenty-four of those states (eighty-three percent) "explicitly stated the ethical principles on which resource allocation decisions should be made" and sixteen (fifty-five percent) included health equity as an ethical consideration.[108] Accordingly, and considering the United States as a whole, just under half of all states (forty-eight percent) have stated ethical norms for resources allocation and just under one-third (thirty-two percent) of all states cite health equity as a guiding ethical principle.[109] Notwithstanding these stated ethical values, the pervasiveness of racism in U.S. society, including in our health care and public health systems and professions, makes it virtually

104. Samuels et al., *supra* note 46.

105. *Id.*; Blake Farmer et al., *Long-Standing Racial and Income Disparities Seen Creeping into COVID-19 Care*, KAISER HEALTH NEWS (Apr. 16, 2020), https://khn.org/news/covid-19-treatment-racial-income-health-disparities/.

106. John Eligon, *Black Doctor Dies of Covid-19 After Complaining of Racist Treatment*, N.Y. TIMES, https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html (last updated Dec. 25, 2020).

107. *Id.*

108. Manchanda et al., *supra* note 31. This survey data was effective as of early May 2020. Similar surveys have been done at about the same time, but this survey asked questions about ethical principles and equity and thus we work with this survey data.

109. *See id.*

inevitable that health policies including CSC embody these racist social relations.

Interpersonal racism, often called discrimination and rooted in implicit or unconscious bias, exists when individuals "deliberately or without intent, treat racial groups differently, resulting in inequitable access to opportunities and resources (e.g., employment, education, and medical care) by race/ethnicity."[110] A systematic review of studies of implicit bias in health care professionals found that these workers have similar levels of bias as the general population, but importantly, this bias affects care: "results also showed that implicit bias was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes."[111] Dr. Moore received poor care as a result of her physician's bias, and similar narratives appear with regularity in the national media wherein Black family members speak of the lack of COVID-19 treatment and undertreatment of their loved ones, often with fatal consequences.[112]

As CSC guidelines have yet to be officially implemented in any U.S. state, no research has studied interpersonal racism in that narrow context. We do know that stressful situations increase the likelihood that implicit biases affect the quality of care and as Powell and Chuang assert, "[t]riage decisions are among the most consequential decisions that can be made about a patient's health."[113] Some CSC suggest or mandate that Triage Officers and Triage Team members undergo implicit bias training. California Guidelines state that the triage team should have expertise in, among other things, "anti-discrimination responsibilities" and "the elimination of implicit and explicit bias."[114] Massachusetts Guidance requires all Triage Officers and Triage Team members to receive implicit bias training.[115]

110. Williams et al., *supra* note 13, at 111.

111. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systemic Review*, 105 AM. J. PUB. HEALTH e60, e60 (2015).

112. Walters & Li, *supra* note 46; John Eligon & Audra D. S. Burch, *Questions of Bias in Covid-19 Treatment Add to the Mourning for Black Families*, N.Y. TIMES, https://www.nytimes.com/2020/05/10/us/coronavirus-african-americans-bias.html (last updated May 20, 2020); *Detroit Health Care Worker Dies After Being Denied Coronavirus Test 4 Times, Daughter Says*, NBC NEWS, https://www.nbcnews.com/news/us-news/detroit-health-care-worker-dies-after-being-denied-coronavirus-test-n1192076 (last updated Apr. 27, 2020, 7:30 PM); Mitropoulos & Moseley, *supra* note 46; *Detroit Man Dies*, *supra* note 46; Annie Waldman & Joshua Kaplan, *Sent Home to Die*, PROPUBLICA (Sept. 2, 2020, 6:30 AM), https://www.propublica.org/article/sent-home-to-die.

113. Tia Powell & Elizabeth Chuang, *COVID in NYC: What We Could Do Better*, 20 AM. J. BIOETHICS, no. 7, 2020, at 62, 63.

114. CAL. DEP'T OF PUB. HEALTH, CALIFORNIA STATE SARS-COV-2 PANDEMIC CRISIS CARE GUIDELINES 20 (2020).

115. DEP'T OF PUB. HEALTH, EXEC. OFF. OF HEALTH & HUM. SERVS., COMMONWEALTH OF MASS., MASSACHUSETTS CRISIS STANDARDS OF CARE: PLANNING GUIDANCE FOR THE COVID-19 PANDEMIC 15 (2020) [hereinafter MASS. DEP'T OF PUB. HEALTH].

While some CSC identify and attempt to address the interpersonal racism of health care workers, all CSC must contend with institutional racism embedded within the CSC themselves. Building on Part II's examination of racism in health care pre-COVID-19 and during the pandemic, Part III identifies particular manifestations of institutional racism present in CSC. In particular, we draw on CSC in Massachusetts,[116] California, [117] Missouri,[118] and at the University of Pittsburgh,[119] collective guidance from The Hastings Center,[120] and the Association of Bioethics Program Directors,[121] as well as various other related documents.[122]

Notably these sources rarely explicitly name racism as a core ethical concern, not to mention analyze it or institute policies to end it. We attend to two critical ways that CSC perpetuate racism. First, the CSC policy-making processes generally include weak representation from Black communities—despite Black communities being among those most impacted by COVID-19. This leads to insufficient knowledge about the communities' needs and preferences, and the result is clinically and ethically harmful outcomes for Black patients. Second, various "objective" allocation criteria and ethical-legal principles in CSC ignore relevant realities of Black lives and result in the deprioritization of Black lives relative to White lives for access to scarce critical care resources such as ICU beds and ventilators. This "objectivity" lends a patina of ethical legitimacy to triage protocols that, if implemented, would exacerbate existing Black health inequities, including in mortality. Part IV charts a more equitable approach for Black participation in CSC creation and implementation.

116. *See generally id.*

117. *See generally* CAL. DEP'T OF PUB. HEALTH, *supra* note 114.

118. *See generally* MO. HOSP. ASS'N, A FRAMEWORK FOR MANAGING THE 2020 COVID-19 PANDEMIC RESPONSE AND IMPLEMENTING CRISIS STANDARDS OF CARE (2020).

119. *See generally* UNIV. OF PITTSBURGH, SCH. OF MED., DEP'T OF CRITICAL CARE MED., ALLOCATION OF SCARCE CRITICAL CARE RESOURCES DURING A PUBLIC HEALTH EMERGENCY (2020); Douglas B. White & Bernard Lo, *A Framework for Rationing Ventilators and Critical Care Beds During the COVID_19 Pandemic*, 323 JAMA E1, E1–E2 (2020).

120. *See generally* NANCY BERLINGER ET AL., HASTINGS CTR., ETHICAL FRAMEWORK FOR HEALTH CARE INSTITUTIONS & GUIDELINES FOR INSTITUTIONAL ETHICS SERVICES RESPONDING TO THE CORONAVIRUS PANDEMIC (2020).

121. *See generally* Amy L. McGuire et al., *Ethical Challenges Arising in the COVID-19 Pandemic: An Overview from the Association of Bioethics Program Directors (ABPD) Task Forc*e, 20 AM. J. BIOETHICS, no. 7, 2020, at 15–27.

122. *See, e.g.*, Ezekiel J. Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of COVID-19*, 382 NEW ENG. J. MED. 2049, 2049–55 (2020).

A. The "Scarcity" of Black Participation

Much has been written about the recommended ethical and clinical elements of CSC and often included is a broad call for community involvement.[123] Yet little normative ethical commentary or analysis focuses on who should participate in creating CSC, what constitutes respectful, equitable community participation, and how decision-making bodies are to be held accountable for such participation.

We know of no systematic research that has examined the processes of CSC creation, whether in individual states or comparatively across states and/or institutions. Ideally, we could examine data regarding the racial makeup of the groups tasked with CSC creation as well as the groups' leadership and actual decision-making processes. Absent such information we can reasonably assume that the persons developing and recommending CSC policies are predominantly White, middle-upper class, able-bodied professionals who make up the clinical and public health leadership ranks from which such committee membership is typically drawn.[124] To the extent that Black physicians, nurses, and health planners are underrepresented in their professions' leadership,[125] they are also likely underrepresented on CSC advisory boards. This "scarcity" and marginalization of Black participation has not gone unnoticed. A trenchant Los Angeles Times editorial about CSC allocation frameworks observes, "[p]eople and groups in power manage to create societies that perpetuate their privilege. They write the rules that allocate emergency care."[126]

Important lessons can be learned about "who writes the rules that allocate emergency care" by examining the process led by the Massachusetts Department of Public Health (MDPH) when developing its April 7, 2020, "Crisis Standards of Care: Planning Guidance for the COVID-19 Pandemic" and two subsequent revisions. In March 2020, the Massachusetts Commissioner of Public Health established a CSC Advisory Working Group that "included medical experts and ethicists from across the Commonwealth, representing both large academic medical centers and community hospitals, and was charged with expeditiously developing recommendations for ethical, equitable and transparent guidelines for providing acute care during a crisis."[127]

123. *Id.* at 2054. *See also* BERLINGER ET AL., *supra* note 120, at 1; McGuire et al., *supra* note 121, at 21; White & Lo, *supra* note 119, at E2.

124. *See, e.g.*, Gretchen Henkel, *Does U.S. Healthcare Need More Diverse Leadership?*, HOSPITALIST (June 2016), https://www.the-hospitalist.org/hospitalist/article/121639/does-us-healthcare-need-more-diverse-leadership.

125. *Id.*

126. L.A. Times Ed. Bd., *Editorial: COVID Treatment Must Be Rationed According to Need, Not Age, Social Rank or Longevity*, L.A. TIMES, https://www.latimes.com/opinion/story/2020-04-25/triage-rules-priority-ventilators (Jan. 8, 2021).

127. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 3.

First published on April 7, 2020, the MDPH Guidance was swiftly critiqued by "advocates for residents with disabilities, older adults, and communities of color."[128] Notably problematic in the Guidance was the recommended scoring system for determining who would receive a ventilator when rationing was required. This algorithm included accounting for comorbidities, conditions that disproportionately affect Black and Latino communities and are largely the result of fundamental societal inequities.[129] In a letter to Massachusetts Governor Baker urging that he rescind these CSC, U.S. Representative for Massachusetts, Ayanna Pressley, noted that "racism and inequality have predisposed communities of color to underlying conditions like diabetes, asthma, and hypertension that heighten the risk of COVID-19 hospitalization and death."[130] In this CSC Guidance, these underlying conditions would lead to these community members being deprioritized to receive ventilators and other scarce resources.[131] Acknowledging that the pandemic will require tough clinical decisions, Pressley declared, "But these decisions cannot be guided by a set of standards that devalues the lives of individuals with disabilities and people of color. Moreover, these guidelines should not be drafted without the engagement and partnership of these communities."[132]

Within two weeks, MDPH added a Black physician/health systems leader to its predominantly White Advisory Working Group and issued "Revised Guidance" that eliminated some problematic features of the CSC.[133] Concerns of communities of color and disability communities persisted and in late August, MDPH set up an "Expanded Working Group" that included additional leaders from Black and disability communities.[134]

128. *Id.*

129. Dialynn Dwyer, *'This Disease Is Just Crushing Communities of Color': Emergency Room Doctors on How COVID-19 Is Laying Bare Inequities in Health Care*, BOSTON.COM (Apr. 24, 2020), https://www.boston.com/news/coronavirus/2020/04/24/health-inequities-coronavirus-massachusetts.

130. Letter from Ayanna Pressley, U.S House of Reps., to Charlie Baker, Governor of Mass. (Apr. 13, 2020), https://pressley.house.gov/sites/pressley.house.gov/files/200413%20Crisis%20Standards%20of%20Care%20Letter.pdf.

131. *Id.*

132. *Id.*

133. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 3; Martha Bebinger, *After Uproar, Mass. Revises Guidelines on Who Gets an ICU Bed or Ventilator Amid COVID-19 Surge*, WBUR (April 22, 2020), https://www.wbur.org/commonhealth/2020/04/20/mass-guidelines-ventilator-covid-coronavirus.

134. The State of Massachusetts is not alone in this sort of late inclusion. After hearing complaints from community groups about a lack of inclusion in the creation of recently released guidelines, "The [California] State Department of Public Health quickly labeled its document a draft and began – appropriately, if quite late in the process – broader outreach in order to develop a more thoughtful set of guidelines," L.A. Times Ed. Bd., *supra* note 126.

This state-level case is instructive in several ways. First, it demonstrates how the lack of inclusion at the start of the policy-making process contributed to the production of recommendations that would have disproportionately harmed Black people and other communities had the Guidance been invoked. Second and relatedly, without sufficient Black representation these recommendations did not adequately recognize and address the health risks and needs of Black persons. Third, this process, though made more inclusive over time, compromised the trustworthiness of public health and health care institutions and likely added to the distrust of health care experienced by many Black Massachusetts residents. To the extent that state CSC planning processes exclude or marginalize Black and other racial communities from membership on standards-making bodies, they embody institutional racism and ultimately produce harmful consequences for these communities.

Another expression of racism is found in CSC advisory group efforts to obtain community input—or not. The Missouri Hospital Association, creator of Missouri's CSC, is clear: "Ideally, this document would have been developed through a deliberative process involving many stakeholders and reviews. However, the need for established guidance at this critical time necessitated the expedited development of a framework for Missouri hospitals."[135] At the time of this writing, eight months after the Missouri framework was issued, it appears from their website that the Missouri Hospital Association has not convened community stakeholders to review or provide feedback on the CSC.[136]

In Massachusetts, the Expanded Working Group's policy-making process differed from that of the previous Working Group in that they "reached out to and met with" concerned persons and groups and solicited online public comment on the revised draft document.[137] Notably, this public input period was only six days long, publicity of the comment period was minimal, and locating the online notice with submission instructions was difficult.[138] The "final revised document" was issued on October 20, 2020, and states that it "makes further changes and clarifications in response to comments received from stakeholders, particularly from members or representatives of vulnerable and marginalized communities."[139]

135. MO. HOSP. ASS'N, *supra* note 118, at 4.

136. Jackie Gatz, *A Framework for Managing the 2020 COVID-19 Pandemic Response and Implementing Crisis Standards of Care*, MO. HOSP. ASS'N (Apr. 20, 2020), https://web.mhanet.com/media-library/a-framework-for-managing-the-2020-covid-19-pandemic-response-and-implementing-crisis-standards-of-care/.

137. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 4.

138. Per the experience of co-author Galarneau.

139. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 4. The Massachusetts Department of Public Health neither posted public comments nor publicly responded to them in writing. *See COVID-19 Public Health Guidance and Directives,* MASS. DEP'T OF PUB. HEALTH, https://www.mass.gov/info-details/covid-19-public-health-guidance-and-directives (last visited

CSC generally affirm public or community input, but the nature, quantity, and quality of actual input encouraged and/or required varies greatly from state to state.[140] Key questions for CSC policymakers include: among the myriad forms of input, consultation, engagement, and participation, what constitutes equitable community input? Who are the appropriate communities for engagement? And who decides which communities are consulted, who constitutes a community representative, how diverse voices and values within a community are negotiated, and what authority community voices are given? One extant form of community input involves listening to and seriously engaging the perspectives of actual communities regarding the values that they believe should guide the allocation of scarce resources.[141]

As an example, there are a wide variety of opinions regarding resource allocation, and the data we have suggests that White communities and Black communities have dissimilar stances. The little data we have about Black community voices and the rationing of scarce critical care resources suggests that Black persons hold values and opinions about ventilator allocation that differ significantly from White persons. In April 2020, the Pew Research Center surveyed U.S. adults about their COVID-19 health concerns.[142] When asked which patients doctors should prioritize when ventilators are rationed, fifty percent of all individuals said the priority should be "patients who are most in need at the moment, which may mean fewer people overall survive, but doctors do not deny treatment based on age or health status," while forty-five percent said "patients who doctors think are most likely to recover, which may mean more people survive, but that some patients don't receive treatment because they are older or sicker."[143] When this data is disaggregated by race, the Black-White differences are significant. Of Black people, sixty percent said doctors should prioritize "patients who are most in need at the moment," and thirty-six percent said doctors should prioritize "patients who doctors think are most likely to recover with treatment."[144] This is in contrast to Whites who responded forty-eight percent and forty-seven percent respectively.[145] As the algorithm central

Jan. 29, 2021) (showing how as of the time of publication, the department's website contained no mention of or response to public comments on CSC).

140. *Compare* Gatz, *supra* note 136 (Missouri policymakers acknowledged the importance of a diverse deliberative process, but CSC were created in an expedited manner, which truncated this community input), *with* MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 4 (Massachusetts policymakers made concerted efforts to make changes based on input from marginalized voices).

141. *See, e.g.*, MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 3–4 (explaining Massachusetts' commitment to changing guidance for scare resource allocation in order to incorporate the values of members of the disabled, elderly, and minority communities).

142. PEW RSCH. CTR., HEALTH CONCERNS FROM COVID-19 MUCH HIGHER AMONG HISPANICS AND BLACKS THAN WHITES 3 (2020).

143. *Id.* at 6.

144. *Id.* at 10.

145. *Id.*

to many CSC privileges prognosis of survival over immediate need,[146] the findings of this nation-wide survey reveal that this reasoning is contrary to the preferred value of a majority of Black Americans.

A 2012–2014 Maryland community engagement study involving 324 adults in fifteen forums found a similar result:

> African American participants had significantly *lower odds* of wanting to always or often use "saving the most life-years" as a criterion for allocation decisions than their white colleagues . . . . Conversely, African American participants were significantly *more likely* to favor often or always using "first come, first served" to drive these key decisions . . . .[147]

A comparative examination of the values of two racially distinct communities in this 2012-2014 Maryland study found differing values, priorities, and concerns.[148] Structured half-day community meetings were held in East Baltimore where sixty-seven percent of attendees were Black and fifteen percent were White, and in Howard County where twenty-one percent were Black and fifty-two percent were White.[149] As groups, each community also varied significantly by income, education, and political affiliation.[150] Researchers found notable differences between the communities, which they attributed to "place-based life experiences:"[151]

> People engage with medical ethics on the basis of their life experiences, social roles, political concerns, and cultural beliefs . . . . People's moral perspectives on medical practice emerge from what they have experienced and learned about the world, including relations of inequality, and not simply from abstract high-order values.[152]

Although race alone was not analyzed in this study, these findings demonstrate that race in conjunction with other social factors shapes community values and moral priorities.

If CSC are to be respectful of and informed by the values of the Black persons and communities they serve, then CSC working groups must include

146. *See* Manchanda et al., *supra* note 31 (discussing exclusion criteria and the consideration of comorbidities built into the CSC of many states as these factors prevent the allocation of scarce resources to people who are unlikely to survive, regardless of the care they receive, and thus maximize the number of lives/life-years saved).

147. E. Lee Daugherty Biddison et al., *Scarce Resource Allocation During Disasters: A Mixed-Method Community Engagement Study*, 153 CHEST 187, 190, 192 (2018).

148. Elizabeth L. Daugherty Biddison et al., *The Community Speaks: Understanding Ethical Values in Allocation of Scarce Lifesaving Resources During Disasters*, 11 ANNALS AM. THORACIC SOC'Y 777, 782 (2014) (discussing how concerns expressed by demographically contrasting communities indicate that there may be differing community ideals regarding resource allocation).

149. *Id.* at 778, 780.

150. *Id.* at 780.

151. *Id.* at 777.

152. *Id.* at 781 (citations omitted).

Black members from the start of the CSC creation process as well as provide additional opportunities for Black community input. Not only must such advisory groups solicit input, but they must also seriously consider it in their production of the substantive ethical and clinical content of the standards. Absent such intentional and structured mechanisms for countering racist marginalization and exclusion, CSC will continue to disproportionately advantage White people while disadvantaging Black people in critical care resources allocation, and thus perpetuate the harms of institutional racism.

B. Objectivity and "Race as Irrelevant"

CSC embody racism not only in the processes of CSC formation as described in Part III.A, but also in the substantive content of CSC. Racism is particularly evident in claims that certain critical elements of the allocation framework are "objective," understood as unbiased, and thus fair or just.[153] Also, assertions that race must be morally irrelevant in fair or just decision-making actually reinforce racism. "Objectivity," understood as race neutrality, and "race irrelevancy" function in part to normalize White values and assumptions, reinforce the Black-White racial hierarchy, and "rationalize the unequal status and degrading treatment of People and Communities of Color."[154] This sometimes explicit, sometimes implicit, norm presumes that fairness means equal or the same treatment and that this sameness affirms equal moral value. This foundational moral grounding is made explicit in the California SARS-CoV-2 Pandemic Crisis Care Guidelines:

> Respect for the moral equality and inherent dignity of each person—regardless of age, disability status, race, or other extraneous factors—requires that all individuals (including people who are undocumented or who are currently incarcerated) be included and evaluated in the same triage pool of individuals receiving treatment in acute care settings.[155]

153. Subini Ancy Annamma et al., *Conceptualizing Color-Evasiveness: Using Dis/Ability Critical Race Theory to Expand a Color-Blind Racial Ideology in Education and Society*, 20 RACE ETHNICITY & EDUC. 147, 149 (2015). Objectivity understood as race neutrality is sometimes called being "colorblind," *id.*, a word we do not use to avoid its imprecision and ableism. We agree that "these terms are inherently problematic, as they do not accurately depict the problem of refusing to acknowledge race while simultaneously maintaining a deficit notion of people with disabilities." *Id.* at 153 (citation omitted).

154. *Id.* at 154 (discussing how a colorblind ideology appears to be racially enlightened, but in reality it perpetuates white supremacy); *White Supremacy Culture*, SHOWING UP FOR RACIAL JUST., https://surjpoliticaledsite.weebly.com/white-supremacy-culture.html (last visited Jan. 24, 2021).

155. CAL. DEP'T OF PUB. HEALTH, *supra* note 114, at 20.

Given our inequitable societal context, equal treatment or sameness typically assumes the particular needs of White people and erases the particular health needs of Black (and many other) people.[156]

"Objectivity" and "race irrelevancy" are expressed in CSC allocation frameworks in three main ways: (1) the Sequential Organ Failure Assessment (SOFA) score; (2) a measure of long-term or post-hospital prognosis; and (3) declarations of race as morally and clinically irrelevant in allocation decision-making.[157] Many CSC frameworks use (1) and (2) as measures to triage critical care patients and allocate scarce resources such as ventilators: the SOFA score is used to evaluate in-hospital survival; and the second measure appraises prognosis of post-hospital survival.[158] Individual patient assessments calculate a patient's combined SOFA plus post-hospital prognosis score, which is then used to determine the patient's priority for limited critical care resources.[159]

1. The SOFA Score

The Sequential Organ Failure Assessment is widely considered to be "an objective and validated measure of acute physiology."[160] Manchanda et al.'s national survey of CSC found that nearly three-quarters of CSC utilized specific allocation frameworks for the rationing of critical care resources, and of those, all recommended the use of SOFA (or modified SOFA) in the priority ranking of patients.[161] Notably, this use of SOFA for the triage of COVID-19 patients is

156. *See* Annamma et al., *supra* note 153, at 158 (noting that colorblind racial views were crafted with white supremacy and unspoken norms in mind).

157. *See* Manchanda et al., *supra* note 31 (discussing the use of the SOFA score, comorbidities as they inform long-term survival, and race-blind guidelines found in nineteen CSC).

158. *Id.*

159. U.C. CRITICAL CARE BIOETHICS WORKING GRP., ALLOCATION OF SCARCE CRITICAL RESOURCES UNDER CRISIS STANDARDS OF CARE 7 (2020). *See also* Emanuel et al., *supra* note 122, at 2052 (noting that scarce resource allocation should be aimed at the dual goals of saving the most lives and maximizing post-hospital life spans); BERLINGER ET AL., *supra* note 120 (discussing how frameworks should be implemented to guide resource allocation during emergencies, as such situations sometimes require physicians to prioritize the community above individuals). Identifying the relationship between a CSC's particular ethical principles and its particular clinical elements is difficult because 1) the ethical principles often are only briefly described, 2) the tensions between ethical principles and values are rarely identified or resolved, and 3) the ethical principles are infrequently explicitly linked to particular clinical practices. *See* White & Lo, *supra* note 119. Meaningfully generalizing links between ethical norms and clinical elements across CSCs is yet more difficult. For example, the ethical principle of maximum benefit to the population is commonly advanced as the central ethical goal of CSC yet it is variously articulated as "the most good for populations of patients," "the greatest good for the greatest number of patients," and "the best possible outcome for the largest number of impacted people." *See id.* at E1. As a result, the ethical principles in CSC often do little substantial moral work in grounding or guiding allocation frameworks.

160. UNIV. OF PITTSBURGH, *supra* note 119, at 1.

161. Manchanda et al., *supra* note 31.

being seriously questioned because SOFA was designed for a different purpose with a different patient population and its validity as a triage tool for COVID-19 patients has yet to be demonstrated.[162] Nonetheless, SOFA scores continue to constitute the core clinical measure in most CSC allocation algorithms as well as the pillar of CSC's core ethical commitment to "save the most lives."[163]

Serious equity concerns arise as SOFA scoring typically includes comorbidities among its considerations.[164] Comorbidities include chronic conditions such as asthma and diabetes that are disproportionately experienced by Black people and are often the consequence of social inequities such as those discussed in Part II.A.[165] Including comorbidities in SOFA scoring results in these patients receiving SOFA scores that lower their priority for needed crisis care.[166] This "objective" measure, when utilized in an inequitable social context where Black people have overall poorer health status than White people, serves to limit Black access to needed care and leads to disproportionate sickness and death.

The Massachusetts CSC acknowledges "the potential" for this problem: "Use of SOFA scoring has the potential to compound existing structural inequities,"[167] and it responds in two ways. First, it asserts that SOFA should be "applied and adjusted in the context of clinical judgment."[168] Second, in cases of patients with chronic kidney disease "who are disproportionately persons of color, who have in turn been disproportionately impacted by COVID-19," it caps the SOFA points given to a specific kidney disease-related indicator: no more than two points may be given for elevated creatinine levels.[169] These responses reflect an important recognition of SOFA's subjectivity and inequitable impact on Black people as well as of the need to limit such harmful impacts. However, these strategies for addressing inequities also have the potential to create disproportionate outcomes for Black patients. Enhanced clinical judgment

162. *SOFA Score: What It Is and How to Use It in Triage*, ASPR TRACIE 1, https://files.asprtracie.hhs.gov/documents/aspr-tracie-sofa-score-fact-sheet.pdf (last updated Dec. 21, 2020). *See* Hannah Wunsch et al., *Comparison of 2 Triage Scoring Guidelines for Allocation of Mechanical Ventilators*, JAMA NETWORK OPEN, Dec. 2020, at 1, 2, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774098; *see also* Douglas B. White & Bernard Lo, *Mitigating Inequities and Saving Lives with ICU Triage During the COVID-19 Pandemic*, 203 AM. J. RESPIRATORY & CRITICAL CARE MED. 287, 288 (2021).

163. Andrew Hantel et al., *US State Government Crisis Standards of Care Guidelines: Implications for Patients with Cancer*, 7 JAMA ONCOLOGY 199, 202–03 (2021).

164. *See* Manchanda et al., *supra* note 31.

165. *Id.*; Emily Cleveland Manchanda et al., *Inequity in Crisis Standards of Care*, NEW ENG. J. MED., July 2020, at e16(1), e16(1).

166. Manchanda et al., *supra* note 31.

167. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 18.

168. *Id.*

169. *Id.*

inevitably allows for additional clinician bias,[170] and SOFA score adjustments would seem to be in order for patients with different chronic disease comorbidities or other health inequities.

Not only are Blacks more likely to have comorbidities when being triaged with COVID-19, emerging research shows that Black persons as compared to White persons are at greater risk of severe illness from COVID-19 infection. Utilizing the U.S. Centers for Disease Control and Prevention criteria, Raifman and Raifman found that Black persons "are more likely to have conditions associated with increased risk of illness from COVID-19," conditions that, like comorbidities, are the result of racism.[171] Furthermore, in a study of hospitalized COVID-19 patients, Black (as well as Latino and Asian) patients who tested positive for COVID-19 "were more likely to require oxygen or ventilation at the time they tested positive."[172] Further analyses controlling for sociodemographic factors and underlying health conditions showed that COVID-19 positive Black patients were thirty-three percent more likely to be hospitalized and nineteen percent more likely to die than COVID-19 positive White patients.[173] Not surprisingly, comorbidities and greater risk of severe illness lead to greater needs for critical care resources, but lower SOFA scores for Black patients.[174]

2. Longer Term or Post-Hospital Prognosis

Prognosis for survival beyond the hospital stay is a second measure used in many CSC allocation algorithms.[175] Typically, if a patient's prognosis for post-hospital survival is less than twelve months, then this patient would be deprioritized for scarce resources as compared to a patient with a five-year

170. *See* Harvard Medical School Center for Bioethics, *Changing the Record: How Bioethics Ought to Address Racism and Bias in Health Care and Beyond*, FACEBOOK (Dec. 3, 2020), https://www.facebook.com/HMSbioethics/videos/116439693532300/ (guest lecturer Yolonda Yvette Wilson argues that "discretion," such as clinical judgment, can reinforce racism); *see also* Yolanda Yvette Wilson, *Bioethics, Race, and Contempt*, J. BIOETHICAL INQUIRY, Jan. 7, 2021, https://doi.org/10.1007/s11673-020-10070-3; Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systemic Review*, BMC MED. ETHICS, 2017, at 1, 13, https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8 (showing twenty out of twenty-five assumption studies found some form of bias evident in the physician's diagnosis, treatment recommendations, patient questions, tests ordered, or other responses).

171. Matthew A. Raifman & Julia R. Raifman, *Disparities in the Population at Risk of Severe Illness from COVID-19 by Race/Ethnicity and Income*, 59 AM. J. PREVENTIVE MED. 137, 138 (2020).

172. Rubin-Miller et al., *supra* note 81.

173. *Id.*

174. *See* MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 18.

175. *Id.* at 17.

prognosis.[176] Such prognoses generally take into account a patient's presumed life expectancy.[177]

Questions abound regarding both the accuracy of clinical prognosis, especially the further out the prognosis occurs, and the use of life expectancy in calculating prognosis. Life expectancy, like the prevalence of comorbidities, differs across racial groups and is related to wide-ranging health inequities.[178] Given the shorter life expectancies of Blacks relative to Whites, the use of life expectancy in prognosis leads to assigning Black people as lower priority and thus a reduced likelihood that they will receive needed care.[179] CSC vary greatly in their use and specific measures of post-hospital prognosis. The State of California does not include post-hospital prognosis in its allocation framework, except in certain tiebreaker cases.[180] The University of Pittsburgh and the Massachusetts CSC gives points to a patient with a twelve month or less prognosis, thus potentially deprioritizing them for critical care.[181]

3. Race as Irrelevant

A third example of how CSC perpetuate racism under the veil of "objectivity" is found in CSC's explicit directives against the consideration of race in clinical decision-making, arguing that race should be "clinically and ethically irrelevant"[182] or "morally irrelevant"[183] in the allocation of critical care resources. In a recent survey, nearly two-thirds of state-based CSC "explicitly articulated that resource allocation decisions should be made without regard to race, ethnicity, disability and other identity-based factors."[184] The California CSC articulates this directive clearly:

> "Consistent with accepted standards during public health emergencies, the goals of the allocation framework are to maximize benefit of populations of patients and honor the ethical commitments to ensure meaningful access for all patients, with determinations based on individualized patient assessments, without regard

176. UNIV. OF PITTSBURGH, *supra* note 119, at 7.

177. *See* MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 19.

178. Manchanda et al., *supra* note 165, at e16(2).

179. *Id.*

180. *See* CAL. DEP'T OF PUB. HEALTH, *supra* note 114, at 13, 26–27.

181. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 18; UNIV. OF PITTSBURGH, *supra* note 119, at 7.

182. COLO. DEP'T OF PUB. HEALTH & ENV'T, EXECUTIVE SUMMARY AND CORE PRINCIPLES: CRISIS STANDARDS OF CARE GUIDELINES FOR HOSPITALS FOR THE COVID-19 PANDEMIC (2020).

183. White & Lo, *supra* note 119 at E2.

184. Manchanda et al., *supra* note 31. Furthermore, some CSC, in addition to directing health care practitioners not to consider race in allocation decisions, advise that Triage Officers and Triage Team members communicate this exclusion of race consideration to patients and families when discussing allocation decisions. CAL. DEP'T OF PUB. HEALTH, *supra* note 114, at 23; MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 16.

> to age, disability, race, sex, sexual orientation, gender identity, immigration status or other factors."[185]

Similarly, the Massachusetts' CSC states:

> "Factors that have no bearing on the likelihood or magnitude of benefit from the provision of medical resources, including but not limited to race, disability, gender, sexual orientation, gender identity, ethnicity, ability to pay or insurance status, socioeconomic status, English language proficiency, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness or past or future use of resources, are not to be considered by providers making allocation decisions."[186]

A closer examination of the above assertions is warranted. In a society and health care system thoroughly shaped by racist norms and practices, does race ever "have no bearing on the likelihood or magnitude of benefit from the provision of medical resources"?

As Kendi observes, "[t]he most threatening racist movement is . . . the regular American's drive for a 'race-neutral state.'"[187] The arguments throughout this Article make plain that race does in fact bear on the likelihood and magnitude of medical benefit received by Black patients. Racism limits Black patients' meaningful access to medical care and other resources and opportunities to be healthy. Denying this racist reality by labeling race "irrelevant" cannot eliminate racism but rather perpetuates harmful health care inequities and further marginalizes already marginalized Black communities.

CSC reflect quintessential White responses to racism. As noted in Part II, when racism in institutional structures and practices is recognized, the response is often to assert that race is irrelevant, paradoxically reinforcing racial hierarchies and inequitable access to care.[188] Conversely, when interpersonal racism, including implicit bias, is recognized, measures are typically implemented to address the problem, therefore making impactful strides to reduce the negative consequences felt by Black communities.[189]

Each of these three examples of institutional racism in the context of CSC—use of SOFA, including its consideration of comorbidities; post-hospital prognosis based in part of life expectancy; and claims of race irrelevancy—exemplifies "color evasiveness."[190] By using color evasiveness, the CSC center

185. CAL. DEP'T OF PUB. HEALTH, *supra* note 114, at 25.

186. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 5.

187. KENDI, *supra* note 34, at 19.

188. Zach Stafford, *When You Say You 'Don't See Race', You're Ignoring Racism, Not Helping to Solve It*, THE GUARDIAN (Jan. 26, 2015, 12:06 PM), https://www.theguardian.com/commentisfree/2015/jan/26/do-not-see-race-ignoring-racism-not-helping.

189. *See, e.g.*, Arlene Hirsch, *Taking Steps to Eliminate Racism in the Workplace*, SHRM (Oct. 22, 2018), https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/taking-steps-to-eliminate-racism-in-the-workplace.aspx.

190. Annamma et al., *supra* note 153, at 156.

dominant or White notions of fairness (assumptions of a level playing field; patient deidentification prevents racist bias) while stripping Black patients of their racial identity, lived experience, culture, and history.[191] Moreover, this CSC racism denies the reality that personal identity and community membership are relevant to health, to accessing high quality health care, and thus to medical benefit. It also excludes or silences Black notions of fairness and equity.

How might we move toward dismantling the multifaceted racism of CSC? To begin, state health departments and health care institutions must adopt an antiracist approach that will guide them in a respectful and participatory process of creating equitable CSC in the name of achieving health equity.

IV. ANTIRACISM AS HEALTH EQUITY

As noted in Part I, Ibram Kendi describes racism as "a marriage of racist policies and racist ideas that produces and normalizes racial inequities."[192] A racial inequity exists "when two or more racial groups are not standing on approximately equal footing." [193] As the analyses in Parts II and III make clear, racist policies in this COVID-19 era include hospital closures in Black neighborhoods, as well as CSC's marginalization of individuals and communities of color in CSC policy creation; its reliance on SOFA and post-hospital prognosis; and its mandates of "race irrelevance." These racist policies are supported by racist ideas including objectivity and race irrelevancy that contribute to the devaluing of Black lives and the strengthening of existing inequities. It is clear that in terms of COVID-19 and CSC, Black and White communities do not stand on equal grounds. It is also clear that policies and ideas that promote the irrelevancy of any racial groups will not dismantle racism in health care or elsewhere. Instead, we need to begin to envision an antiracist approach to health equity among racial groups.

In simple terms, antiracism requires us to ask whether any particular health policy, proposed or existing, leads to health equity and whether it reduces or reproduces health inequities.[194] Similarly, do the fundamental ideas and values undergirding health policies affirm that all racial groups are equally valuable? Do they uphold the idea that inferior policies, and not inferior people or their behaviors, produce inequities? What might an antiracist CSC—one that promotes racial health equity—look like? What antiracist ideas might undergird antiracist CSC practices?

191. Nneka O. Sederstrom, *Unblinded: Systemic Racism, Institutional Oppression, and Colorblindness,* BIOETHICS.NET (May 7, 2020, 9:00 AM), http://www.bioethics.net/2020/05/unblinded-systematic-racism-institutional-oppression-and-colorblindness/.

192. KENDI, *supra* note 34, at 17–18.

193. *Id.* at 18.

194. *See* WORLD HEALTH ORG., HOW CAN HEALTH EQUITY IMPACT OF UNIVERSAL POLICIES BE EVALUATED? INSIGHTS INTO APPROACHES AND NEXT STEPS 33 (Beth Milton et al. eds., 2011).

First and foremost, an antiracist CSC would make health equity its central value and goal. Health equity has multiple and overlapping articulations. Some policymakers focus on its aim:

> Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[195]

Others focus on what health equity is not: "[h]ealth equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[196] And still other institutions, like the American Public Health Association, combine these two dimensions into a succinct, pro-equity statement:

> We believe in conditions that give everyone the opportunity to reach their best health. This requires valuing all individuals and populations equally. It means addressing inequities in the places where people are born, grow, live, work, learn and age. When will we know we have succeeded? When health disparities are eliminated.[197]

What might health equity mean in relation to health policies like CSC in the time of COVID-19? If healthy equity means maximizing the conditions and opportunities needed for the maximum health for all, then our first goal might be to create the clinical and societal conditions such that CSC and their rationing are not needed. Sheri Fink, a keen chronicler of medical triage during public health emergencies (in particular, post-Hurricane Katrina), suggests that the most important lesson from the first COVID-19 surge in spring 2020 might be that "creativity, improvisation and national values that reject rationing can help avoid some tragic choices."[198] Part IV explores a current state public health effort to center health equity and reviews a CSC revision that attempts to minimize CSC inequities. Part IV ends with a description of "first steps" we believe are necessary for creating the conditions for antiracist CSC.

A. Health Equity at the State Level

At least one state has brought a health equity lens to bear on the COVID-19 pandemic. In spring 2020, the Commissioner of the Massachusetts Department

195. BRAVEMAN ET AL., *supra* note 10, at 2.

196. *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 (last visited Jan. 29, 2021).

197. *Our Values*, AM. PUB. HEALTH ASS'N, https://www.apha.org/about-apha/our-values (last visited Jan. 29, 2021).

198. Sheri Fink, *Ethical Dilemmas in Covid-19 Medical Care: Is a Problematic Triage Protocol Better or Worse than No Protocol at All?*, AM. J. BIOETHICS, July 2020, at 1, 4.

of Public Health established a COVID-19 Health Equity Advisory Group comprised of more than two dozen representatives of communities of color, disability communities, and organizations that serve these communities.[199] The function of the group was "to generate a series of recommendations for the Commissioner of Public Health on how the COVID-19 pandemic response could be informed by a health equity lens to ensure equitable access to resources and services, and prevent injuries and disproportionate negative outcomes."[200] The Advisory Group issued its recommendations in June 2020, including some tasks directly related to the Massachusetts CSC.[201]

The Advisory Group set out a general COVID-19 Mitigation recommendation: "[w]ork to ensure all populations have equitable access to needed therapies, vaccines, trials, and other necessary medical care,"[202] and notes the root causes of the access problem as, "[r]esources allocated in [an] inequitable manner; discrimination/racism in healthcare and [a] history of trauma/distrust related to unethical testing practices."[203] They identified the primary groups affected by the access problem as "People of Color (race/ethnicity), sexual orientation and gender identity, people with disabilities, people with limited English proficiency and those with low literacy, immigrant communities with focus on undocumented, low-income, individuals who are incarcerated."[204]

To address this access disparity in COVID-19 care, the Health Equity Advisory Group advised a series of CSC relevant tasks including (in part) to:

- Build equity into resource planning to ensure adequate supply and prioritize identified populations . . .;
- Allocate resources based on immediate lives saved—do not allocate resources based on presumed quality of life;
- Update the crisis standards of care as they relate to the allocation of resources, including treatments and vaccinations, and remove the consideration of five-year survival . . .;
- Provide education that everyone deserves equal access to treatments to all stakeholders;

199. *COVID-19 Health Equity Advisory Group*, COMMONWEALTH OF MASS., https://www.mass.gov/orgs/covid-19-health-equity-advisory-group (last visited Jan. 29, 2020).

200. *Id.*

201. MASS. DEP'T OF PUB. HEALTH, DEPARTMENT OF PUBLIC HEALTH COVID-19 HEALTH EQUITY ADVISORY GROUP RECOMMENDATIONS 1, 21 (2020).

202. *Id.* at 21.

203. MASS. DEP'T OF PUB. HEALTH, DPH COVID-19 HEALTH EQUITY ADVISORY GROUP: RECOMMENDATIONS, DPH POTENTIAL ACTIONS & UPDATED DATA RELEASE 38 (2020).

204. *Id.*

- Include diverse stakeholders at every conversation point around access and allocation; and
- Increase available resources to avoid scarcity.[205]

The antiracism/health equity questions to be asked of each of these recommendations and tasks are: does it lead to health equity? Does it reduce or reproduce health inequities?

These recommendations and related tasks were published on the MDPH website without comment about their possible future use or implementation, though the Public Health Commissioner who chaired this Advisory Group affirmed, "[a]t the Department of Public Health, our mission is to eliminate health inequities and we place equity at the core of all that we do."[206] Notably nothing in the latest version of the Massachusetts CSC—created by another MDPH Advisory Group and issued four months after the Health Equity recommendations were publicly released—suggests that these recommendations or the Health Equity Advisory Group were consulted in the creation of the CSC. This raises a concern about the nature of accountability for professed commitments to health equity and to antiracism.

B. Health Equity in CSC

Shifting to CSC, remember that a significant number of CSC affirm a commitment to health equity as an important ethical principle.[207] As one CSC expressed it, "[e]very effort has been made to use equity as the foundation of the framework."[208] Less clearly stated is the meaning of health equity and how health equity is embodied throughout the elements of the allocation framework. In a recent effort to reduce some of the inequities commonly built into CSC, White and Lo have proposed what is essentially a revision to the University of Pittsburgh allocation guidelines which have been widely adopted, partially or wholly, by states and institutions across the United States.[209] Like many CSC creators, they call for equity to be a fundamental ethical goal of CSC alongside the "efficiency goal" of saving the maximum number of lives.[210] Unlike many others, they articulate and advocate for a trio of inequity mitigation strategies. First, they call for adjusting the SOFA scores of certain patients recognized as disadvantaged. Second, they recommend giving essential workers higher priority status for critical care resources. And third, they advise to eliminate

205. *Id.* at 37–38.

206. Press Release, Mass. Dep't of Pub. Health, Department of Public Health releases recommendations of COVID-19 Health Equity Advisory Group to address pandemic's impact on communities of color (June 19, 2020).

207. Manchanda et al., *supra* note 31.

208. MASS. DEP'T OF PUB. HEALTH, *supra* note 115, at 10, 11.

209. *See* White & Lo, *supra* note 162, at 287.

210. *Id.* at 290.

consideration of life expectancy in determining post-hospital survival.[211] Given an antiracist/health equity approach we must ask, does this policy lead to health equity? Does it reduce or reproduce health inequities?

While this policy revision would appear to reduce certain inequities, it also leaves intact and without comment other fundamental inequities such as the lack of participation by Black and other persons and communities in the CSC policy-making process. The revised triage protocol calls for "robust public engagement" about "how a particular society will balance efficiency and equity."[212] Yet, communities are not invited to discern what the principles of efficiency and equity mean for their groups, what practices or strategies they believe best reflect those ethical principles, nor more fundamentally, what ethical principles communities themselves believe should guide a triage protocol. Absent addressing participation, the revised CSC will continue to reinforce the racist privileging of White participation leading to standards of care that do not fully reflect the realities of Black needs and preferences, and thus to poorer quality care and to more Black lives lost or compromised. Realizing an antiracist CSC characterized by health equity will require a much deeper reconsideration of ethical principles and clinical protocols by a much wider group of persons and communities than are participating in current conversations.

C. Achieving Antiracism and Health Equity: First Steps

Given the deep entrenchment of racism throughout our society and health care system as articulated in Parts II and III, achieving health equity for Black communities will require that we take an intentionally antiracist approach to health policy. We suggest that the first steps will require that all involved in health policymaking gain a deep understanding of three ideas (and realities) central to antiracist health policy: racism, community, and community participation.

First, a health equity-driven CSC would identify the multi-faceted ways that racism is embedded in current CSC policy as well as the actions needed to dismantle it. Such an analysis would require a thorough understanding of the embedded racism including race as a social, political, and economic construct; its historical origins in the United States; and its White supremacy ideology of inferiority/superiority,[213] the disproportionate resources and opportunities it offers, and ultimately the inequities in health and health care it produces.[214] Such

211. *Id.* at 291–92.

212. *Id.* at 291.

213. Charlene Galarneau, *True Colors: Whiteness in Bioethics*, 21 AM. J. BIOETHICS 33, 34 (2021).

214. RUQAIIJAH YEARBY ET AL., INST. FOR HEALING JUST. & EQUITY, ST. LOUIS UNIV., RACISM IS A PUBLIC HEALTH CRISIS. HERE'S HOW TO RESPOND 5–6 (2020); Valerie Wilson,

an understanding of racism would make easily recognizable the many health inequities in the contemporary health care landscape and render untenable any assumption of a "level playing field," provided by race neutrality or race irrelevancy.

Regarding community, a health equity-driven CSC would appreciate that communities—racial, ethnic, disability, religious, local, and more—are critical moral entities as are the individuals and populations (state or patient group) now recognized in CSC.[215] Racism identifies people as members of racial communities, not as individuals, and then creates a hierarchy among communities with stratified and unequal resources and opportunities.[216] Health and health care are community goods as well as individual and population level goods and as such, communities must play a significant ethical role in anything we call just or equitable health care.[217] The frequent erasure of communities is evident in the common ethical framing of CSC as a blend of clinical care ethics, focused on individual patients, and of public health ethics, focused on the entire population (or the population of patients).[218] "Population" obscures the morally relevant communities that comprise it.[219] The CSC labeling of race as "morally irrelevant" and then prohibiting its consideration in allocation decision-making denies the irrefutable reality that all patients are members of particular racial communities that affect their health and health care.[220] That said, the "relevancy" of race is recognized in some CSC in the acknowledgement that SOFA can perpetuate existing health inequities including racialized ones.[221]

Furthermore, we need to recognize diversity within any given community as well as among communities. As one Boston health leader put it:

> We have to be community-specific . . . . Oftentimes we talk about Black and brown communities as if we're one big community. In the city of Boston, that's 55, 60 percent of the population. So we have to be [a] little bit specific in thinking about individual communities and their needs.[222]

Director, Program on Race, Ethnicity, & Econ., Econ. Pol'y Inst., Testimony Before the U.S. House of Representatives Committee on Education and Labor (June 22, 2020).

215. Charlene Galarneau, *Communities Matter*, 50 HASTINGS CTR. REP. 63, 63 (2020).

216. *Race and Racial Identity*, NAT'L MUSEUM OF AFR. AM. HIST. & CULTURE, https://nmaahc.si.edu/learn/talking-about-race/topics/race-and-racial-identity (last visited Jan. 29, 2021).

217. CHARLENE GALARNEAU, COMMUNITIES OF HEALTH CARE JUSTICE 1 (2016).

218. *E.g.*, *Crisis Standards of Care Ethical Framework*, MINN. DEP'T OF HEALTH, https://www.health.state.mn.us/communities/ep/surge/crisis/framework_ethical.pdf (last visited Jan. 29, 2021).

219. Galarneau, *supra* note 215, at 64.

220. *Id.* at 63.

221. Joseph Park, *Ethics and Racism in Crisis Standards of Care*, BOS. CITY EM (Sept. 16, 2020), https://bostoncityem.com/2020/09/16/ethics-and-racism-in-crisis-standards-of-care/.

222. Dasia Moore, *New Study Finds Staggering Racial Disparities in COVID-19 Cases in Massachusetts*, MSN (Aug. 27, 2020), https://www.msn.com/en-us/news/us/new-study-finds-staggering-racial-disparities-in-covid-19-cases-in-massachusetts/ar-BB18rlZN.

Finally, an antiracist CSC guided by health equity would instill community participation with decision-making authority and power.[223] As noted in Parts I and II, racism is about power, wherein the racial group in power uses such power to disadvantage other racial groups. Antiracist, health equity-driven, community participation must include a shift in power. Currently, many CSC call for community engagement or participation in vague terms absent mention of the power or authority of that participation.

Mindful that antiracism requires antiracist policies to be undergirded by antiracist ideas, "community justice" entails a commitment to "effective voice," as it promotes the serious engagement of community-based values and norms such that they shape laws and policies.[224] For example, the values and priorities of Black community members regarding the allocation of critical care resources in Maryland described in Part III.A must be used in creating the substantive clinical aspects of CSC. This requires institutions to partner with communities in "true collaboration with shared decision-making, building alliances, and community involvement throughout the entire process, not merely for completing certain tasks. Additionally, racial and ethnic minorities must be given equal power in crafting laws, policies, and practices that will address their current needs and redress past harms."[225]

Community justice requires structuring opportunities for participation through innovative institutional mechanisms: in addition to increasing the number of elected positions, for example, health board members, "advisory groups, boards, commissions, focus groups, and town hall meetings," as well as "participatory councils, assemblies, or coalitions" can encourage effective voice.[226] "Surveys, polls, and individual interviews alone are not suitable, as they typically lack the dialogic engagement necessary for effective voice."[227]

In the COVID-19 pandemic, the Massachusetts Health Equity Advisory Board offers guidelines for such participation: it calls for engagement that "[puts] those with lived experience at the center of this process," "[allows] enough time to engage stakeholders," and "[invests] in the capacity of existing partner organizations."[228] It requires the formation of a distinct strategy "for the active engagement and representation of existing anchor organizations in the communities in decision-making processes related to COVID-19 response and

223. *See* YEARBY ET AL., *supra* note 214, at 8; Galarneau, *supra* note 215, at 64; Emily A. Benfer et al., *Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, YALE J. HEALTH POL'Y, L., & ETHICS 122, 162 (2020).

224. GALARNEAU, *supra* note 217, at 71 (noting these community-based values must include those of religious communities); Patrick T. Smith, *Thinking Ethically About Pandemics: A Matter of Public Health and Social Ethics*, 20 REV. DE ESTUDIOS DA RELIGIÃO 105, 115 (2020).

225. YEARBY ET AL., *supra* note 214, at 10.

226. GALARNEAU, *supra* note 217, at 75.

227. *Id.*

228. MASS. DEP'T OF PUB. HEALTH, *supra* note 203, at 27.

recovery."[229] It names the "priority communities" for participation as those communities characterized by "race, class, and language, those that have historically received the least resources, racially and ethnically, low income, ability, immigration status, insurance status, [and] history of incarceration."[230]

Communities often include multiple community-based organizations that have worked long-term at reducing inequities experienced by their communities and are experts in representing the needs and preferences of their communities.[231] Some such groups have formed in response to COVID-19, for example, the Black Boston COVID-19 Coalition, described as:

> a group of stakeholders and thought leaders from Boston who have formed a united effort to demand that decisions, policies, and actions taken and resources committed to our community of residents and businesses are effective. We define effective as successfully stemming the contraction and transmission of COVID-19, and leaving Black residents and Black businesses in a better place post-pandemic than we were before and during. We believe that the only way to accomplish our mission is to interject ourselves into every aspect of the response and recovery process. We are prepared to do whatever is necessary.[232]

Community councils at the national, state, local, and institutional levels are another example of structured opportunities for community participation.[233] During the COVID-19 pandemic, the Los Angeles County supervisors unanimously approved a program "in which workers from certain sectors will form public health councils to help ensure that employers follow coronavirus safety guidelines."[234] This example can be used for community engagement in creating community councils to address the equitable allocation of health care services during pandemics. The councils would work in partnership with the federal government, state health departments, state task force, and health care systems/institutions to develop, approve, implement, and evaluate decisions regarding access to testing, treatment, and what should be included in CSC.

National level endeavors such as The Praxis Project's Centering Community in Public Health promote partnerships between local community organizers and public health/health care leaders "to bridge the priorities and needs of their respective communities with the legislative power of decision-makers, and activate community members through a range of civic engagement

229. *Id.* at 24.

230. *Id.* at 26.

231. *See* JAMES N. WEINSTEIN ET AL., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 190 (2017).

232. *About*, BLACK BOS. COVID-19 COAL., https://blackbostoncoalition.org/about (last visited May 30, 2021).

233. Yearby, *supra* note 15, at 4.

234. Leila Miller, *L.A. County Approves Program for Workers to Form Public Health Councils to Curb Coronavirus Spread*, L.A. TIMES (Nov. 10, 2020, 3:45 PM), https://www.latimes.com/california/story/2020-11-10/la-me-la-county-public-health-councils.

strategies."[235] Communities have a great deal to say about health equity and the obstacles to it. The question is whether health leaders are willing to structure opportunities for community participation that center the experiences of community members, include them as decision-makers in CSC formation, and invest in building community voice and power.[236]

Health equity and antiracist health policy require significant short- and long-term policy changes in all sectors of society to create the conditions and opportunities for optimal health for all. As one group of CSC commentators aptly observes, "it is unrealistic to think that health equity will be achieved without a major investment of resources. Where a society devotes its financial resources indicates its values. Therefore, it is perverse to say that we value health equity if aren't willing to make the investments necessary to redress inequities."[237]

At the start of 2021, many states are, once again, close to or surpassing ICU bed capacity and on the verge of implementing their CSC.[238] Will the racist features of CSC be allowed to persist? Or will we resist by investing in an antiracist, pro-health equity future that empowers communities?

V. CONCLUSION

COVID-19 has laid bare the racial inequalities in access to resources, which have resulted in health and health care inequities for Black people. Black communities, and other marginalized communities, must be given the power and ability to address inequities during the COVID-19 pandemic. Specifically, Black communities, in partnerships with the federal government, state health departments, and health care systems/institutions, should make decisions regarding access to health care and the contents of CSC. These partnerships could ensure that CSC reflect the Black communities' needs and values including redressing the past harms of institutional racism. For these partnerships to work, all involved must adopt an antiracist, pro-health equity approach. While it has become commonplace in this COVID-19 era post George Floyd's murder to assert that racism is a public health crisis, racism has been a chronic health crisis in the United States for centuries. We have no "standards of care" for this crisis. Health equity, with its commitment to create the

235. *Centering Community in Public Health: Organizing Against Systemic Racism During COVID-19*, PRAXIS PROJECT 11 (2020), https://www.thepraxisproject.org/resource/2020/organizing-against-systemic-racism-during-covid19.

236. *Id.*

237. Seth A. Berkowitz et al., *Covid-19 and Health Equity – Time to Think Big*, NEW ENG. J. MED., Sept. 2020, at e76(1), e76(3).

238. Lauren Leatherby et al., *'There's No Place for Them to Go': I.C.U. Beds Near Capacity Across U.S.*, N.Y. TIMES (Dec. 9, 2020), https://www.nytimes.com/interactive/2020/12/09/us/covid-hospitals-icu-capacity.html; Press Release, Ass'n of Am. Med. Colls., AAMC Calls for Implementation of Crisis Standards of Care to Address COVID-19 Surge (Nov. 30, 2020).

conditions for everyone to reach their best health, is the standard of care we need. Only then can we truly begin to work towards improving the health and well-being of Black communities and all racial and ethnic minorities.

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