Acknowledging the Burdens of 'Blackness'

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Abstract

The novel coronavirus of 2019 exposed, in an undeniable way, the severity of racial inequities in America's healthcare system. As the urgency of the pandemic grew, administrators, clinicians, and ethicists became concerned with upholding the ethical principle of "most lives saved" by re-visiting crisis standards of care and triage protocols. Yet a colorblind, race-neutral approach to "most lives saved" is inherently inequitable because it reflects the normality and invisibility of 'whiteness' while simultaneously disregarding the burdens of 'Blackness'. As written, the crisis standards of care (CSC) adopted by States are racist policies because they contribute to a history that treats Black Americans are inherently less than. This paper will unpack the idealized fairness and equity pursued by CSC, while also considering the use of modified Sequential Organ Failure Assessment (mSOFA) as a measure of objective equality in the context of a healthcare system that is built on systemic racism and the potential dangers this can have on Black Americans with COVID-19.

Keywords COVID-19 · COVID-1619 · Racism · Crisis standards of care · SOFA score · Colorblind · Ideal and nonideal

Acknowledging the Burdens of 'Blackness'

Black America is burdened by two pandemics: the novel coronavirus of 2019, also known as COVID-19, and the ever-present illness of racism, or what is referred to as COVID-1619 (Brennan 2020). While American healthcare has devoted much attention to the former, the latter has been mostly ignored. COVID-19 exposed, in an undeniable way, the severity of the racial inequalities in America's healthcare system. As the urgency of the pandemic grew, the ethics community focused on addressing the principle of "most lives saved" and States worked on establishing crisis standards of care and triage protocols. These triage protocols reflect the

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normality and invisibility of white supremacy in America, which allows our medical institution to continue to systematically oppress and discriminate against Black Americans during times of crisis. The COVID-19 pandemic revealed the depth of racial disparities, rendering the idea of equitable allocation of resources during COVID-19 inconceivable.

Uniform policy actions have consistently disregarded the burdens of 'Blackness' and the complicated relationship 'Blackness' has with the management and treatment of COVID-19. This oversight is not due to deliberate malice but is a direct result of this country's acceptance of white supremacy as the standard. Society has thrived in a deliberate colorblind culture where the majority believe being antiracist means not acknowledging color or race. Dr. Ibram Kendi in his book *How to be an Antiracist* helps to rectify this gross misunderstanding. Ibram X Kendi defines racist as one who allows racial inequities to persevere and an antiracist as one that confronts racial inequities (2019). To truly address both the COVID-19 and COVID-1619 pandemics, we must be intentionally *antiracist* in our actions and policies. We agree with him that there is no "not racist" neutrality. Idealized, utilitarian approaches to allocate resources during times of crisis allow for racial health inequities to continue, making such an approach racist in nature.

As written, the crisis standards of care documents adopted by many States are not antiracist policies, but rather, are racist policies because they perpetuate and maintain a history of inequality towards Black Americans. Thus, crisis standards of care policies can be seen as not just racist, but more specifically anti-black policies because they minimize, marginalize, and devalue the full inclusion of Black lives in crisis decision-making. Allocating resources with an "objective" notion of "most lives are saved" assumes objectivity that is more compatible with the ideal experiences of a white American while remaining silent and incompatible to the atypical concerns of a Black American. Until we address the inherent anti-blackness in this idealized utilitarian approach to public health, we will continue to sustain and promote health inequity, inequality, and systemic racism.

Inequality in COVID-19

Social distancing, handwashing, and wearing a mask are the most effective, known strategies to reduce the spread of the COVID-19 virus, but these uniform public health recommendations fail to consider alternative solutions for those who lack the privileges needed in order to capitalize on these strategies. The ability to work a job that allows one to work from a home, the ability to convert all social activities onto a virtual platform with the technology available to make that platform function, and the money to afford high quality cleaning materials and surgical masks are just a few of the privileges needed. The lack of intentional public health policies and practices to account for these inequities is a failing of the system and the reason Black America is suffering disproportionately. Without diverse voices that can address the complex social systems, our agencies will continue to fail Black America and the burden of Blackness will continue to directly impact morbidity and mortality for Black Americans.

We acknowledge that other communities of color, especially the Latinx community and Indigenous community, are also disproportionately impacted by the novel coronavirus. However, we focus on the particular impact COVID-19 has had on the Black community specifically because of the historical trauma of Black people in America and the need for a reconciliation with that past. According to the Centers for Disease Control and Prevention (CDC), despite only representing 13% of the US population, Black Americans make up 26% of COVID-19 cases, 31% of COVID-19 related hospitalizations, and 23% of COVID-19 related deaths (2020). The largest disparities were detected in the Midwest, where Black Americans accounted for 30-40% of COVID death rates in Kansa, Missouri, Michigan, and Illinois, despite representing less than 15% of the populations in those states (University of Utah 2020). In Wisconsin, Black Americans only represent 6% of the population yet account for more than 36% of the state's COVID deaths (University of Utah 2020). A John Hopkins and American Community Survey showed, of 131 predominantly black counties across the United States, the infection rate is 137.5 per 100,000 and the death rate is 6.3 per 100,000 (Yancy 2020). This is an infection rate that is more than 3-fold higher in predominantly black counties than those observed in predominantly white counties, and a death rate that is 6-fold higher than in predominantly white counties. After analyzing data from the CDC, Kaiser Health News came to the conclusion that specifically older Black Americans are the most at risk of dying from COVID-19 (Plater 2020). Their report stated that Black Americans ages 65 to 74 died from COVID-19 at a rate five times greater than white Americans. For ages 75 to 84, the death rate of Black Americans was 3.5 times higher.

These disproportionate infection and death rates can partly be explained by socioeconomic conditions that exist because of the unique caste system set up in America to continue systematically oppressing members of the Black community (Wilkerson 2020). Black Americans are the poorest racial group in the United States. They are more likely to live in crowded urban settings, be exposed to higher levels of small-particle pollutants, to have lower quality schooling, to have less access to healthcare and health foods, be incarcerated, and to live in violent environments (Noonan et al. 2016). Black Americans are also more likely to develop chronic conditions such as diabetes, cardiovascular disease, and asthma. Hypertension is most prevalent in Black Americans, even at early ages, compared to other races (Doumas et al. 2020). The confluence of these chronic conditions is known to place individuals at a higher risk of COVID-19 related complications and mortality (Yancy 2020).

On the other hand, after adjusting for sociodemographic factors and underlying diseases, a recent study suggested that the all-cause COVID-related mortality for Black Americans was not statistically significant in conjunction with white Americans (Yehia et al. 2020). However, the data is very incomplete in this study, with only 45% of the race information from patients being recorded. Without in depth review and scrutiny of the data, such a study could be cited as justification for halting the efforts to change crisis standards of care policies. The incomplete data and subsequent conclusion are a perfect example on how the academy continues to push the narrative of equality instead of addressing the need for intentional interventions as a result of the inequality. According to the authors, their findings suggest "that while Black US residents may be at higher risks of contracting COVID-19

and represent a disproportionate share of COVID-19 death, mortality for those able to access hospital care does not differ from white patients" (Yehia et al. 2020). It is red herring articles such as this that attempt to bracket systemic racism away from our hospitals, a conclusion that is less controversial and more palatable for white America. Yet white America must get comfortable with the uncomfortable in order to ethically address inequities and lift the burden of Blackness.

Crisis Standards of Care

During times of medical crisis, a rapid influx of patients is expected to exceed the hospital's capacity and critical resources (i.e., beds, ventilators, staff, and medications). This creates a shortage where institutions are left with addressing demand and re-allocation decisions. As a response to the 2009 H1N1 Influenza pandemic, the Institute of Medicine (IOM) produced nationwide guidelines for establishing CSC for use in disaster situations. Crisis standards of care (CSC) are considered an effective and ethical way to shift from a healthcare that is individual patient-centered to a just healthcare that allocates resources based on a utilitarian ideology such that the most lives are saved. Utilitarian ethics considers the right action to be that one that promotes the greatest good for the greatest number of people (maximize utility). CSC adhere to a utilitarian ethics by prioritizing those most likely to benefit:

> When resource scarcity reaches catastrophic levels, clinicians are ethically justified – and indeed are ethically obligated – to use the available resources to sustain life and well-being to the greatest extent possible. As a result, the committee concluded that ethics permits clinicians to allocate scarce resources so as to provide necessary and available treatments preferentially to those patients most likely to benefit when operating under crisis standards of care. (2010, p. 6)

During a crisis or catastrophic event, the IOM suggest (1) the response offers the best care possible given the resources at hand, (2) decisions are fair and transparent, (3) policies and protocols are consistent within and across states, and (4) citizens and stakeholders are included and heard (2010, p. 18). Laws and the legal environment must also support the efforts. These are considered to be key elements to a CSC.

These guidelines follow the CDC's recommended approach to a procedural-based justice, with the hope that following good procedures will lead to *fair* outcomes (Kinlaw and Levine 2007, p. 5). The uniformed, procedural framework suggested by the IOM aims to respond to crises in a way that is both fair and equitable. The IOM defined fairness as "standards that are, to the highest degree possible, recognized as fair by all those affected by them" (2009, p. 3). The IOM goes on to spell out equity in terms of *transparency* in design and decision-making, *consistency* in application regardless of factors like, but not limited to, race, age, disability, ethnicity, and ability to pay, and *proportionality* to the scale of the emergency and degree of scarce resources (2009, p. 3).

CSC pursues a utilitarian aim by means of a procedural notion of distributive justice that relies on a neutral, "objective" framework to ethical decision-making. The IOM envisioned a CSC that is color-blind, class-blind, able-blind, and need-blind. Their report explicitly defines equity as an equal distribution of scarce resources *regardless* of human differences. In fact, many CSCs explicitly state that using race as an indicator for decision making is forbidden. The rationale behind the explicit exclusion of race is that triage officers or team members should avoid any potential bias that would come by knowing the race of a patient. Moreover, there is a deep seeded belief that acknowledging or making decisions based on race is unconstitutional.

However, in other domains, often equity is associated with the acknowledgment of human differences. How many of us have seen the image of three people attempting to watch a baseball game from behind a wooden fence? One of the persons is depicted as tall, another depicted as average-height, and the last depicted as short. Equality is illustrated as giving each of the persons an equal-sized box to stand on. The result: the tall person remains able to see the game, the average-person can now see over the fence, but the shorter person's visual remains blocked. Equity is then illustrated as accounting for the differences, by allocating a box based on their human condition. The result: the tall person receives no box given they could always see, the average-person receives the one box needed to see over the fence, while the shorter person receives an additional box and is finally placed in an equal position as the others. In reality, the work on addressing inequality should seek to remove the barrier but for the sake of this article we will continue to use the original explanation. It is also important to note that the physical disadvantage of height is analogous with the physical disadvantage of Blackness. Both are traits that one has no control over yet directly impact how they navigate our society.

By choosing to be blinded to social human differences, CSC provides a distorted notion of equity and provides an ethical framework that assumes an equal footing when allocating scarce resources. The distributive justice being pursued is one that requires that the same procedures apply to all. Yet, implementing a "same rules apply to all" allocation standard protocol in a systematically unequal and racialized social context—more specifically, a racialized context full of health inequities—disproportionately affects the already disadvantaged (DeBruin et al. 2012). While institutions and state governments scrambled to get ahead of the pandemic wave and establish CSC policies couched in an ethical framework, none presumed to address the impact these standards would have on the Black community. It is not an insult to state this fact because the reality is being intentional at assuming how policies and practices impact the Black community is a foreign practice, often done only as an afterthought when the evidence shows a significant impact. This notion of equity is thus silent to the systemic racism forming the bedrock of American healthcare, perpetuating and exacerbating structural violence towards Black Americans.[1]

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[1] Structural violence is a term coined by Johan Galtung, used to describe a systemic inequitable social arrangement, or structure. The violence is built into the systemic inequitable social arrangement, and shows up as unequal power and consequently as unequal life changes. Structural violence is perpetuated by institutions that prevent members of vulnerable groups from adequately meeting their needs. For more, see:DeBruin et al. (2012, p. 586) and Farmer et al. (2006, p. 1686).

A Color-Blind "Most Lives Saved"

The IOM suggests incorporating a decision tool to provide consistency and evidence during decision-making. Many states use a Sequential Organ Failure Assessment (SOFA) score to decide ventilator allocations as a core component of their CSCs (IOM 2010). For example, the Massachusetts's CSC Planning Guidance for the COVID-19 Pandemic (2020) recommends allocating resources using a mSOFA (or modified SOFA) score that determines the most lives saved and the most life-years (Table 1). The SOFA score characterizes patients' prognosis for hospital survival (i.e., the most lives saved), and the presence of significant life-limiting comorbid conditions is used to characterize patients' longer-term prognosis (i.e., the most life-years saved). Priority is then given to those who's lower scores indicate a higher likelihood to benefit from critical care.

The SOFA score is a colorblind measure. Using a colorblind SOFA score to determine the "most lives saved" is inherently inequitable, and in the context of American society, racist. It assumes an equal footing between all COVID-19 patients, disregarding any differences pertinent to systemic inequalities and oppression. The racialized reality is such that, before taking into account the effects of COVID-19, current social determinants of health categorize Black Americans as a "lower priority." Black Americans have shorter life expectancies than white Americans and 70 to 80% of that difference can be explained by systemic racist socioeconomic factors (Manchanda et al. 2020).

Moreover, SOFA scores can be read as overvaluing abled, white lives and further devaluing disabled lives and lives of people of color. SOFA was originally created to predict mortality of persons (majority white) with sepsis in an intensive care unit (Lambden et al. 2019). As a result, using a SOFA score or any other standardized comorbidity assessment to determine the "most lives saved" does not fairly factor Black lives into the decision-making process. Advocating for Governor Charlie Baker to rescind Massachusetts's CSC, U.S. Rep. Ayanna Pressley writes,

> We know communities of color are more likely to have comorbidities not because of any genetic predisposition, but due to the legacy of structural racism and inequality that has resulted in unequal access to affordable healthcare, safe and stable housing, and quality schools and employment. (Manchanda et al. 2020)

CSCs deprioritize individuals with comorbid conditions or with a higher likelihood of death within 5 years, and as Pressley states, "devalue the lives of individuals with disabilities and people of color" (Manchanda et al. 2020). CSCs devalue those individuals who have conditions rooted in historic and current inequities, and by presenting as a colorblind and race-neutral policy, they continue to sustain and exacerbate pre-existing health inequities.

Table 1 Multi-principle strategy to allocate critical care to adult patients during a public health emergency. Retrieved from Massachusetts' CSC Planning Guidance for the COVID-19 Pandemic (2020, p.17)

Principle	Specification	Point system[a]			
		1	2	3	4
Save the most lives	Prognosis for short-term survival (SOFA score)	SOFA score <6	SOFA score 6-9	SOFA score 10–12	SOFA score >12
Save the most life-years	Prognosis for Long-term survival (medical assessment of comorbid conditions)	…	Major comorbid conditions with substantial impact on long-term survival	…	Severe comorbid conditions; death likely within 1 year

SOFA Sequential Organ Failure Assessment

[a]Persons with the lowest cumulative score will be given the highest priority to receive critical care services

Racism in an Idealized Utilitarianism

"Most lives saved" is a utilitarian approach in medicine. Saving the most lives possible during a pandemic is the ideal scenario. Here, ideal refers to a principle or value (i.e., justice, fairness, equity) actively being pursued. However, in pursuing the ideal of "most lives saved", CSC simultaneously idealizes a particular view of the world—colorblindness. Idealizes in this second sense refers to a distorted, perfected representation of reality. This particular approach to "most lives saved" has trouble accounting for the *non*ideal conditions of our society. In determining the "most lives saved", we must be reflective on whose reality is being assumed and universalized in our decision-making framework.

Allocating from Privilege

Philosophers Onora O'Neill (1989) and Charles Mills (2005) discuss idealized approaches to justice, idealizing in the second sense, both noting how such approaches often seem to endorse practices and policies that benefit the privileged.

An idealized approach to justice is one that abstracts from the particularities of persons and is often blinded to differences in social power and resources (O'Neill 1989, p. 3). However, as idealized approaches to justice abstract from particular human features (i.e., race, ethnicity, gender), they almost always idealize a specific conception of a person, a conception that is more reflective of the experiences or perspective of the privileged. Idealizing of this kind then functions to only serve the interest of the privileged as it abstracts away from realities that are crucial to our understanding of the actual workings of inequities and injustices in America. As a colorblind and race-neutral policy, CSC dangerously idealizes the white perspective through a guise of impartiality and objectivity. To intentionally abstract away from the systemic structures that result in racial differences while prioritizing those most likely to presently benefit, is to allocate resources from a privileged position that can afford to consider the present crisis in isolation from American medicine's racially violent past and inequitable present. There is an overarching acknowledgment in medicine that we can and do need to do better in addressing racial health disparities in America. However, in implementing CSC as written, we are saying systemic and institutional racism are something we cannot focus on during the COVID-19 pandemic. We are saying "it is not the right time" and "it will be too much of a distraction."

There is a level of privilege that comes with whiteness to construct a policy that recognizes we can do better, but explicitly states that racism is too difficult to focus on during a crisis. While for Black Americans, the experience of COVID-19 and race cannot come apart. The crisis is a constant state of being, not just a recent phenomenon. Because Black Americans are lowest on the racial hierarchy and are a part of the "subordinate caste" to quote Isabel Wilkerson (2020), their perspective is one that simultaneously considers the past, present, and future. Any approach to justice is dangerous when it perpetuates a hidden white ⟨male⟩ male ideology—a

distortional congruence of ideas, values, norms, and beliefs that reflect the nonrepresentative interests and experiences of those in a position of social privilege (2005, p. 172). What makes it particularly dangerous in this case, is the CSC, as an idealized approach to distributive justice that excludes racial differences, is a privileged perspective that not only continues to serve the interests of white Americans but does so at the potential cost of Black and Brown lives.

CSC decision-making frameworks utilize an idealized social ontology and are silent on oppression. Both are additional evidence that such an approach stems from a privileged position of whiteness (Mills 2005). An idealized social ontology typically abstracts away from relations of structural domination and oppression and assumes "undifferentiated equal atomic individuals'' (Mills 2005, p. 168). Colorblindness invokes such an idealized social ontology. The colorblindness in mSOFA scores, and in CSC more broadly, fosters decisions from an idealized assumption that patients occupy an equal, undifferentiated relation to the social structures that knowingly influences the presence of comorbidities. By being colorblind, one assumes an idealized, never-achieved reality of racial equality, making the acknowledgment of race unnecessary and obsolete. Thus, colorblind health policies disregard power differentials and the influence they have on disparities in health outcomes. They also disregard the biased human behind the decision making and assume a neutrality that is not real. In the case of CSC, it assumes health outcomes can and should be weighed equally across races by socially conscious individuals during times of crisis. Only those not subject to adverse social determinants of health are privileged to be colorblind in health policies; only those not subject to higher rates of comorbidities benefit from the explicit exclusion of race.

As Sociologist Charles Gallagher notes, colorblindness is a dominant lens through which white Americans are more likely to understand contemporary race relations (2003, p. 25). CSC were a by-product of the H1N1 influenza pandemic, which occurred during what many news media outlets reported to be a "post-racial" America during the Obama-Era. However, where white Americans are more likely to see a level playing field, the majority of Black Americans see a field that is still uneven (Gallagher 2003). Colorblindness perpetuates whiteness by being blinded to the privileges and structural dominations of whiteness. Gallagher (2003) writes,

> The color-blind perspective removes from personal thought and public discussion any taint or suggestion of white supremacy or white guilt while legitimating the existing social, political, and economic arrangements which privilege whites …. This perspective ignores, as Ruth Frankenburg puts it, how whiteness is a "location of structural advantage societies structured in racial dominance" (2001 p. 76). (p. 26)

The ability to ignore race reflects a position of power and privilege that does not reflect the interests and experiences of many Black Americans. Whiteness gets further normalized. Idealized approaches are uncritical of the privileges they are abstracted from (O'Neill 1989, p. 3). Much of the ethical principles governing healthcare in the United States is deeply rooted in a white ideology of individualism (Myser 2003). For decades, medical ethics has been uncritical as to whose ethics we are practicing and as to what social perspective our theorizing comes from.

Utilizing such language as "objective", an idealized approach to justice hides a universally applied white perspective under the guise of a colorless view from nowhere. This allows for white ideology to remain unnoticed in the pursuits of desired health equity. By keeping white ideology hidden in colorblindness and race-neutrality, we risk reproducing the white privilege, white supremacy, and structural violence against Black Americans during already devastating times of crises.

Given data shows that Black Americans already have lower health outcomes and are more likely to contact the novel coronavirus, implementation of colorblind CSC will likely place Black Americans in the "back of the line" for critical care resources, actualizing this risk of further violence against Black lives.

Acknowledging the Burdens

O'Neill and Mills both suggest that the best way of realizing justice is through the recognition of the importance of theorizing the *non*ideal (1986; 2005). The primary purpose of proposing an ethical framework is to guide our actions towards the ideal case.[2] However, if the ethical framework assumes a distorted, idealized reality, then the framework "will not only be unhelpful, but will in certain respects be deeply *antithetical* to the proper goal" (Mills 2005, p. 170). Without considering the actual workings of historic and current injustices in American healthcare, adopting a colorblind framework will maintain a dissonance between the inequitable reality and the fair and equitable goal, guaranteeing that equity, even in times of crisis, will never be achieved. On the other hand, a *non*idealized approach to justice acknowledges the crucial racialized realities that differentiates the statuses of the persons within the system the ethical framework is describing and responding to.

To guide our actions towards a just healthcare system within the context of a pandemic, a *non*idealized CSC would first not assume a shared starting position from which to then perform any assessments. We propose the burdens of Blackness should be acknowledged in such policies if equity and justice during times of crisis is truly the goal. By acknowledging race, CSC would acknowledge structural racism and any assessments will have to incorporate this in their evaluation. As Bonilla-Silva notes "racism produced (and continues to produce) 'races' out of peoples who were not so before" (2015). In other words, acknowledging race in a health policy is not stipulating race to be a biological concept. But rather, it is recognizing race to be a social construct that, for some, comes with physical disadvantages. The comorbidity differences between Black and white Americans are not because Black Americans are somehow physiologically different, but rather, the comorbidity differences are deeply influenced by socioeconomic differences and persistent systemic racism. These socioeconomic differences result from centuries of dehumanizing and othering those who are visibly or perceived to be of African descent (Wilkerson 2020). As an antiblack society, Blackness is still viewed and responded to as inherently inferior and primitive, robbing Black people of the opportunity to equal

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[2] Here, ideal refers to ideal in the first sense: a principle or value (i.e., justice, fairness, equity) actively being pursued.

socioeconomic footing. Factoring in race would provide CSC with a less distorted equity lens, allowing for resource allocation to factor in notions of power and privilege instead of devaluing a Black life under an "objective" or "equal" guise.

In response to the COVID-19 pandemic, a *non*idealized approach seems to also be suggested in an article written by the National Institute on Minority Health and Health Disparities (NIMHD):

> Strategies that are culturally appropriate and community competent and that consider the nuances of population, community, family, and individual differences have a vital role in reducing health disparities, promoting health equity, and improving population health. (Hooper et al. 2020)

Universalizing assuming a level (white) privilege through the promotion of color-blind, uniform strategies during the COVID-19 pandemic has been less effective for Black Americans. Social distancing mandates assumed a universal opportunity to work from home. According to researchers at the University of Utah, Black Americans disproportionately worked in nine essential occupations that increased their exposure to the novel coronavirus. Their report showed Black Americans were nearly three times more likely to work in healthcare support jobs (i.e., nursing assistants or orderlies) compared to white Americans, were twice as likely to work in transportation roles (i.e., bus drivers, movers, taxi drivers), and overall, more likely to serve in essential occupations related to food preparation, building and grounds maintenance, and police and protective services (University of Utah Health 2020). The researchers showed healthcare support, transportation, food preparation, and police and protective services were among the essential occupations most closely correlated with COVID-19 related deaths. These findings strongly suggest that Black Americans are more likely to occupy essential jobs, placing their loved ones and themselves at a higher risk of exposure to the virus.

Moreover, when the CDC urged all Americans to wear a face covering, Black men were not only worried about the virus, but also worried their covered faces would be perceived as threatening. One man tweeted, "I am a Black man living in this world. I want to stay alive, but I also want to stay alive" (Taylor 2020). Consider the death of Elijah McClain, a 23-year-old Black man who was killed by police in 2019 after he entered a convenience store wearing a ski mask for his anemia and was reported for looking "sketchy." Such police killings have made it even more difficult for Black Americans to comply with the social distance mandates, as a series of protests broke out across the country after yet another policing killing of a black man. This time his name was George Floyd. Protesters acknowledged the threat of COVID-19 was ever-present, but that standing up for racial injustice was "worth the risk" (Harmon and Rojas 2020). By acknowledging such burdens of Blackness, a *non*idealized CSC would require forgoing our engrained discomfort with naming race and ethnicity as an intentional factor in decision-making.

Lastly, a *non*idealized CSC would not vaguely gesture at the burdens of Black Americans as if the lived experiences of oppression and exploitation is merely a deviation from what white Americans take to be the reality of America and America's healthcare system. Treating the burdens of Black Americans as a deviation would be tangentially acknowledging such burdens, but not necessarily embedding

those experiences into the procedures used to allocate resources during a pandemic. Currently, the IOM's CSC guidelines do just this. Recognizing the importance of building trust in populations with preexisting health inequities and unique needs related to race and ethnicity, the IOM writes

> Individuals from these communities may have accentuated mistrust for governmental decision making and the healthcare system, and these concerns may parlay into their questioning the fairness and equity of the process during the implementation of crisis standards of care. (2009, p. 42)

Yet, this racially informed mistrust and questioning are bracketed away from the construction of the procedures used to pursue the very ideals of fairness and equity. On the other hand, having the experiences of vulnerable populations built directly into the process, and having the SOFA score be racially adjusted or corrected, would make it more likely that the desired ideals of fairness and equity be achieved. There is something that can be done to alleviate the burden of Blackness and many are attempting to be courageous enough to incorporate these much-needed changes. Concerns about being intentional with naming and identifying race in these processes need to be met with open minds and creativity instead of fear and a tendency to back down because moving forward is hard.

Reparations for COVID-1619 in COVID-19

In a previously published blog article entitled *The "Give Back": Is There Room For It?*, one of the authors (Sederstrom) described a mechanism for addressing the overly weighted proverbial backpack of Blackness.[3] It was proposed that the SOFA scoring system should be changed to allocate points back to Black Americans, to alleviate some of the burden of blackness for patients being triaged during CSC. "Give back" points for the patient being from a historically disadvantaged racial population in America, and "give back" points for a patient who currently resides in an area of resource deprivation. Using this simple system of reallocation to correct for racism is one way to be deliberate, intentional, and antiracist. Such a 'give back' system does not result in an environment where the intentional favoring of Black patients nets a positive over other patients. We are deliberate in using the points as a mechanism for amelioration for historical trauma thereby creating a net zero starting point. This creates an opportunity to level the playing field from which then utilitarian principles can be more successfully employed. This is a form of medical reparations and is the kind of direct antiracist action that is needed to end racism.

The natural question about how other people of color like the Latinx community fair in a "give back" system is always raised when thinking through operationalizing this process. The answer can be explained in a weighted system that accounts for differences in patients of color and socioeconomic conditions. The

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[3] The proverbial backpack of Blackness contains the systemic, institutional, and structural racism that weighs down Black Americans.

heavier weight of points to "give back" to self-identified Black Americans is simply because they have shouldered the burden of a society that has systematically oppressed them throughout their entire existence on this continent. Other minority groups do not have the historical trauma that comes with this distinction and therefore cannot be put in the same category. Addressing a "give back" system must account for populations that have sanctioned trauma and oppression. Native Americans would be weighted similarly while socioeconomically disadvantaged white Americans would not. An example of how this process could work would be 2 points for a patient who is from a historically oppressed racial/ethnic group, 1 point for a patient from other communities of color, and 1 point for a patient from a socioeconomically disadvantaged population. That could result in Black and Native American patients receiving a maximum of 3 points, Latinx patients receiving a maximum 2 points, and white patients receiving a maximum of 1 point for socioeconomic concerns only.

Conclusion

We acknowledge that at the time of this writing, the belief that any State in the Union would declare CSC and enact triage protocols is low. Currently, policy concerns are aimed at emerging therapeutic treatments and how to account for racism in assumed upstream population health initiatives. Despite no pressing need to allocate scarce resources, we still contend that the time is now to actively address the racism in CSC models. Let's use this "calm" to formulate better options for creating equity so that we can truly live up to the IOM's call for fairness. Now is the time to do something. This cannot wait for a time when we are out of the COVID-19 pandemic because the COVID-1619 pandemic has been raging for far too long. The argument that making significant social justice progress will take community consensus before adoption has been used to attempt to negate this work. The reality is waiting for the majority of the community to embrace acceptance forces progress to stall and results in more lives lost. We must have these conversations. The 'give back' is a proposed starting point and we are eager to engage in further intellectual discourse. What is not acceptable is silence or maintenance of the system.

   We intentionally discussed the impact on Black Americans and no other populations of color because of the unique history of chattel slavery in America and its impact on Blacks. There is a tendency to lump all ethnic minorities together, which can undermine the specific lived experiences of being Black during the COVID-19 pandemic. Over 400 years since the first African slave was brought to the United States, and Black Americans are still suffering the effects. None of us are free, until all of us are free. Centering on those at the margins will improve health outcomes for all but doing so requires white Americans to share in the experience of a racially determined health outcome. To truly be equitable and just, we must engage in intentional amelioration and intentional antiracism.

Compliance with ethical standards

Conflicts of interest We have no conflicts of interest to disclose.

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