

Unequal Access: The Bioethics of Racism in the Time of COVID-19



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Introduction

It is well-known that Black people in the United States have received unequal medical treatment since the 1600s. However, what is seldom interrogated is the ethical basis that has historically shaped – and continues to shape – the decision-making process behind this unequal distribution of resources. In healthcare, the study and evaluation of such ethical concerns is known as bioethics, a subdiscipline of philosophy. Reconsideration of bioethical principles that have shaped our healthcare system is urgently needed if we seek to change the ethical system that has enabled the unequal distribution of health care resources to the Black community.

This white paper will show how the ethical principles that determine the distribution of healthcare resources are inherently racist and have their roots in the unethical decision-making process used by slaveholders in the 18th and 19th centuries. As long as these harmful principles remain unquestioned, they will continue to silently shape and inform the kinds of decisions healthcare providers make when serving Black patients.

Background

While the formal field of bioethics emerged in the late 20th century, the issue of who does and does not deserve care has always been debated. In this section, we will trace the history of a few key historical healthcare decisions that have negatively affected the treatment of Black people in the US, along with the ethical principles that supported such treatment. We aim to highlight how these unethical practices and their justifications are deeply ingrained and continue to inform decision-making in the present.

In order to ensure the functionality of the new economy fueled by slave labor, colonial lawmakers developed rules to address the contradictory dual status between treating Africans (and others) as persons held to labor – in which case as persons they were deserving of health

care and other human rights – or as property owned by other people, and as such, undeserving of human rights, including health care.¹ Lawmakers struggled with how to address this contradiction since, for example, there were free Africans in some states; some Africans were Christians; and some Africans rebelled and refused to accept enslavement – all of which were regarded as confirmations of personhood. Moreover, in the 1700s, the South, after initially denying personhood to the enslaved, reversed its position when they realized that by granting partial personhood (the 3/5ths person rule) they could increase the political representation of Southern states in the electoral system.

However, in all cases of treatment of the enslaved, lawmakers regarded enslaved Black people as property. Famously, the Supreme Court case *Dred Scott vs. Sandford* denied all present and future Black people of personhood, citizenship, and thus moral human rights.² As a result, slave owners had no legal obligation to attend to the health care of their “property.” In fact, slave holders were free to beat, torture, and kill the enslaved with impunity. As far as medical treatment, slave owners were driven by profit and thus they typically only cared for the health of enslaved Black people they deemed most productive, and withheld medical care from those regarded as less productive.³ By denying personhood to Black individuals, they were able to deny Black individuals the right to healthcare customarily accorded to others, making it socially, ethically, and legally justifiable for slaveholders to withhold medical care. This reasoning would become the uninterrogated basis of many decisions regarding medical treatment for Black people in the United States made thereafter.

¹ Allain, Jean, ed. *The Legal Understanding of Slavery: From the Historical to the Contemporary*. Finkelman, Paul. (2012). *Slavery in the United States Persons or Property*. Oxford: Oxford University Press, 2012. Oxford Scholarship Online, 2013. doi: 10.1093/acprof:oso/9780199660469.001.0001.

² Understanding the Tools - SMU. (n.d.). Retrieved July 28, 2020. <https://www.smu.edu/Provost/Ethics/Resources/EthicsToolBox/UnderstandingtheTools/MoralRightsTheoreticalBackground>

³ Lander, Kevin, and Jonathan Pritchett. "When to Care: The Economic Rationale of Slavery Health Care Provision." *Social Science History* 33, no. 2 (2009): 155-82. Accessed August 30, 2020. doi:10.2307/40267997

The ratification of the Thirteenth Amendment in 1865 put an end to slavery and to African Americans being legally regarded as property. However, well into the Jim Crow era, the health needs of Black people, who were now *legally* full American citizens, were still not addressed by the government and medical practitioners. Instead, false medical narratives of Black people having higher pain thresholds, and thicker skin and skulls now became the justification for retaining hierarchies of labor and citizenship. Anthropologist Karl Christoph Vogt provides an example of this physiological justification for continued abuse. In his *Lectures on Man*, Vogt informed readers that “the Negro stands far below the white race” in terms of the “acuteness of the senses.” Rather than attribute the endurance of Black people to enlightened custom or educated sensibility, but Vogt insisted it was due to a physiological disposition.⁴ This racist, essentialist “research” contributed to the pseudo-ethical justification for lower quality of care.⁵

The medical neglect faced by Black people was yet again justified in 1896 by the “separate but equal” doctrine of the Plessy v. Ferguson court case, where it was held that the 14th Amendment applied to only political and civil rights.⁶ Therefore it remained acceptable to have separate, well-equipped and well-funded medical facilities for whites that were able to turn away colored patients.⁷ Black people were compelled to go to hospitals that were severely underfunded and understaffed. Once again, unequal treatment of Black people was rationalized

⁴ Beecher, HK., Sir William. Bennett, L. Bertrand, WA. Bourne, GR. Butler, A. Carman, CM. Jones WP. Chapman, et al. “Pain Sensitivity: An Unnatural History from 1800 to 1965.” *Journal of Medical Humanities*. Springer US, January 1, 1970. <https://link.springer.com/article/10.1007/s10912-014-9283-7>.

⁵ Randall, Vernellia. “Slavery, segregation and racism: trusting the health care system ain’t always easy! An African American perspective on bioethics.” *Saint Louis University Public Law Review.*, (1996). 15(2), 191–235. AND Plous, S., & Williams, Tyrone. “Racial Stereotypes From the Days of American Slavery: A Continuing Legacy.” 1995 Retrieved from <https://www.socialpsychology.org/pdf/jasp1995b.pdf>

⁶ History.com Editors. “Plessy v. Ferguson.” History.com. A&E Television Networks, October 29, 2009. <https://www.history.com/topics/black-history/plessy-v-ferguson>.

⁷ “Professional and Hospital DISCRIMINATION and the US Court of Appeals Fourth Circuit 1956–1967 | *AJPH* | Vol. 94 Issue 5.” Accessed August 30, 2020.

<https://ajph.aphapublications.org/doi/10.2105/AJPH.94.5.710>.

AND Smith, David Barton. *Eliminating Disparities In Treatment And The Struggle To End Segregation*. (2005, August) Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2005_aug_eliminating_disparities_in_treatment_and_the_struggle_to_end_segregation_775_smith_ending_disparities_in_treatment_pdf.pdf

and justified by the U.S. Supreme Court, and the immoral ethics shaping medical treatment remained unchallenged.

The negative health consequences upon Black communities due to lack of funding, resources, infrastructure, and trained physicians were, if anything, exacerbated in the 1900s. Politicians and local health authorities, including the American Medical Association (AMA), continued to neglect the needs of minorities. They justified this position on the basis that medical care was available to anyone in need – a position that was far from the truth.⁸

The Hill Burton Act of 1946, a federal law that provided funds for the construction of hospitals and other medical facilities, had the potential to be the first piece of legislature to make inroads in health equity, but instead it prioritized the needs of white Americans through the unequal distribution of medical resources.⁹ Beds and other resources were distributed by local and state discretion, and local medical chapters of the AMA suggested how funds should be used. Black people were not allowed membership in these medical associations and those in power were able to divert funds away from poorly funded hospitals serving Black people on the basis that the "colored wards" of segregated hospitals were enough. These wards often consisted of nothing more than a hallway or a random section of a hospital.¹⁰

⁸ Ibid.

⁹ Weeks, Lewis and Berman, Howard, *Shapers of American Health Care Policy: An Oral History*. Health Administration Press. 1965.

¹⁰ Smith, D. B. (2005, August). Eliminating Disparities In Treatment And The Struggle To End Segregation. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2005_aug_eliminating_disparities_in_treatment_and_the_struggle_to_end_segregation_775_smith_ending_disparities_in_treatment_pdf.

Modern Day

Centuries of intentionally unjust distribution of medical resources that neglected the needs of minorities and naturalized racist stereotypes have widened the health divide over time. According to the United States National Center for Health Statistics, in 2003 over 40% of Black beneficiaries rated their health as poor or fair, in contrast to 25% of their white counterparts similarly rating their health as poor or fair.¹¹ Other studies have shown that, compared to their white counterparts, African American adults are 40% likelier to have high blood pressure, three times as likely to die from an asthma-related complication, and 60% likelier to be diagnosed with liver cancer; they also account for 44% of HIV cases in the United States.¹² Figure 1 below highlights the prevalence of comorbidities among different racial groups in COVID-19 hospitalizations and death. In general, the data show that black patients experience comorbidities at a much higher rate compared to the broader sample population of white patients and patients of other races. For example, 74.6% of hospitalized Black patients and 86.7% of Black patients who died had comorbidities. Across all racial groups, patients who were hospitalized or who died had higher rates of comorbidities than the overall sample population, which highlights how comorbidities within the Black population contribute to their increased COVID-19 infection and death rate.

¹¹ Care, Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health, Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. THE IMPACT OF COST CONTAINMENT EFFORTS ON RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE: A CONCEPTUALIZATION. National Academies Press (US), 2003. <https://www.ncbi.nlm.nih.gov/books/NBK220345/>.

¹² "Asthma and African Americans - The Office of Minority Health." Accessed August 5, 2020. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=15>. AND "Chronic Liver Disease and African Americans - The Office of Minority Health." Accessed August 5, 2020. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=17>. AND "Heart Disease and African Americans - The Office of Minority Health." Accessed August 5, 2020. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19>. AND "HIV/AIDS and African Americans - The Office of Minority Health." Accessed August 5, 2020. <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=21>.

Comorbidities in COVID-19 Hospitalizations and Deaths – Aged 19-64 Years

by Race, Compared to Studied Population (n = 16,702,587)

Population	Race	Asthma	COPD	Diabetes	Hypertension	COPD + Diabetes	COPD + Hypertension	Diabetes + Hypertension	COPD + Diabetes + Hypertension	Other Combination	None
Studied Population	Black	0.5%	0.4%	2.6%	16.7%	0.1%	0.7%	6.7%	0.6%	0.6%	71.1%
	White	0.5%	0.9%	2.1%	12.5%	0.1%	0.8%	3.6%	0.5%	0.4%	78.6%
	Other	0.4%	0.3%	2.1%	7.1%	0.0%	0.2%	2.9%	0.1%	0.2%	86.7%
COVID-19 Hospitalizations	Black	0.7%	1.0%	7.8%	25.9%	0.6%	2.2%	29.5%	4.4%	2.4%	25.4%
	White	0.8%	2.2%	6.2%	21.0%	0.8%	3.0%	15.7%	3.7%	1.9%	44.6%
	Other	0.7%	0.9%	10.3%	16.6%	0.4%	0.9%	18.1%	1.1%	0.9%	50.0%
COVID-19 Deaths	Black	0.2%	1.8%	10.6%	21.3%	0.9%	2.9%	38.4%	8.2%	2.4%	13.3%
	White	0.2%	4.0%	8.0%	17.7%	1.5%	6.2%	22.3%	11.0%	2.5%	26.7%
	Other	0.6%	3.4%	13.7%	15.1%	2.1%	2.3%	27.9%	2.4%	1.1%	31.5%

Figure 1¹³

In addition to current comorbidities within the Black population, the theme of disproportionate attention and increased access to testing given to wealthier, whiter communities continues to shape the present.¹⁴ When the COVID-19 virus reached the U.S. and closures began happening in March of 2020, resources were already scarce and a centuries-old pattern of unequal allocation showed its face once again. Hospitals in minority communities were left in dire need, while some other hospitals were getting supplies. Data from New York City, for example, point to disparities in terms of who had access to testing. The total number of

¹³ Levinscherz, Jeff, Ken Chang Administrator, Administrator, and Dwight O Eichelberger. "Race, Comorbidities, and COVID-19." Epic Health Research Network, July 2, 2020. <http://ehrn.org/race-comorbidities-and-covid-19/>.

¹⁴ Michael Biesecker, Michelle R. Smith. "Celebrities Get Virus Tests, Raising Concerns of Inequality." AP NEWS. Associated Press, March 19, 2020. <https://apnews.com/b8dcd1b369001d5a70eccdb1f75ea4bd>; McMinn, Sean, Audrey Carlsen, Bret Jaspers, Ruth Talbot, and Stephanie Adeline. "In Large Texas Cities, Access To Coronavirus Testing May Depend On Where You Live." NPR. NPR, May 27, 2020. <https://www.npr.org/sections/health-shots/2020/05/27/862215848/across-texas-black-and-hispanic-neighborhoods-have-fewer-coronavirus-testing-si>.

tests administered rose in direct correlation with the percentage of white residents; in turn, the proportion of *positive* tests decreased with white population.¹⁵ The overall death rate from COVID-19 among Black communities due to poor health and lack of equitable healthcare has been disproportionately high across cities and states in the U.S. For example, in Chicago, Black people made up 68% of COVID-related deaths despite only being 30% of the city's population.¹⁶ In Michigan, Blacks make up 15% of the state population but represent 35% of people diagnosed with COVID-19 and 40% of the total COVID-19 deaths in the state.¹⁷

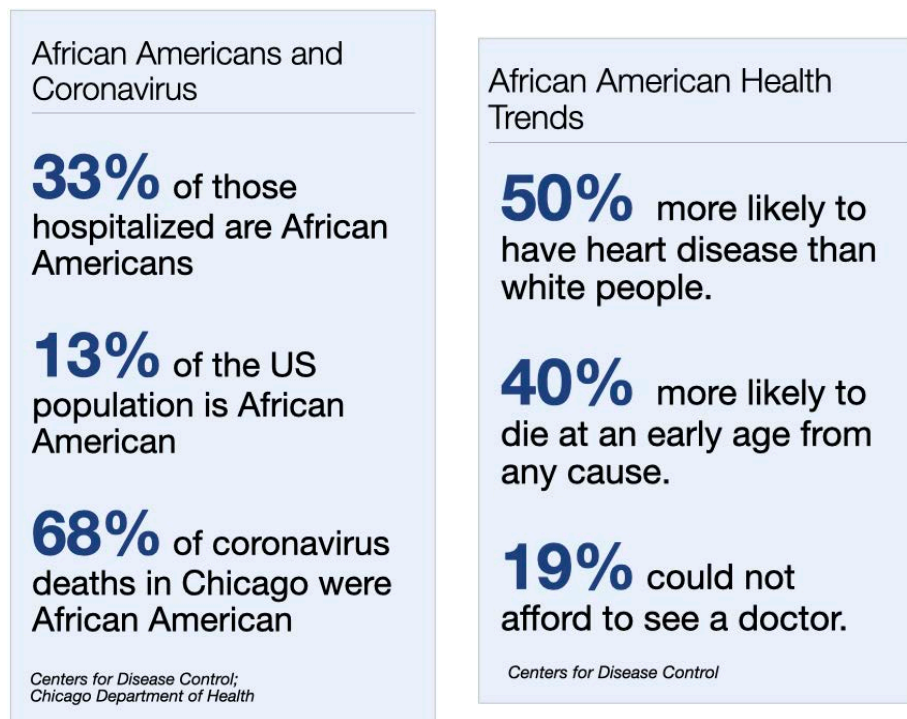


Figure 2¹⁸

¹⁵ Kelly Servick Jul. 10, 2020, 2020 Jocelyn Kaiser Aug. 28, 2020 Lucy Hicks Aug. 28, 2020 Rebekah Tuchscherer Aug. 26, 2020 Rasha Aridi Aug. 21, and 2020 Cathleen O'Grady Aug. 21. "Huge Hole' in COVID-19 Testing Data Makes It Harder to Study Racial Disparities." *Science*, July 10, 2020. <https://www.sciencemag.org/news/2020/07/huge-hole-covid-19-testing-data-makes-it-harder-study-racial-disparities>.

¹⁶ Flynn, Meagan. "Those Numbers Take Your Breath Away': Covid-19 Is Hitting Chicago's Black Neighborhoods Much Harder than Others, Officials Say." *The Washington Post*. WP Company, April 7, 2020. <https://www.washingtonpost.com/nation/2020/04/07/chicago-racial-disparity-coronavirus/>

¹⁷ Ray, Rashawn. "Why Are Blacks Dying at Higher Rates from COVID-19?" *The Brookings Institution*. Brookings, April 19, 2020. <https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/>.

¹⁸ As reported in "Coronavirus: Why Some Racial Groups Are More Vulnerable." *BBC Future*. BBC. Accessed September 1, 2020. <https://www.bbc.com/news/world-us-canada-52245690/>.

The COVID-19 pandemic has shined a harsh light on medical resource allocation and guidelines, suggesting that decision-making must shift from a racist, white-privilege notion of ethics in order to address the health needs of minority communities. In the next section, we will explore the typical bioethical principles of medical resource allocation in order to determine how they facilitate racist ethics, and how they might be reconfigured to be more fair and inclusive in this pandemic and in the future.

Bioethical Principles

Bioethical principles guide health care providers in the moral decisions involved with treating patients. As we have discussed, there is a problem with these principles and their applications insofar as there are clear and longstanding disparities that disproportionately harm racially disadvantaged communities, especially Black communities.¹⁹ In this section we will explore the basic ethical principles that most health care providers and bioethicists rely upon for moral guidance: nonmaleficence, beneficence, and distributive justice. Providers are asked to balance the demands of these three principles in their decision-making. However, as we will demonstrate, these principles have never been made to confront the disparate treatment of disenfranchised Black communities. In examining these principles, we will ask whether these principles have the capacity to be inclusive or whether they are inherently racist.

¹⁹ "Principles of Bioethics." Principles of Bioethics | UW Department of Bioethics & Humanities. Accessed September 1, 2020. <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics>.

Nonmaleficence – Do No Harm

In medical ethics, a healthcare provider's guiding principle is "First, do no harm," otherwise known as nonmaleficence. This principle asserts that patients have the right to expect that their healthcare provider will not intentionally harm or injure them, whether through acts of commission or omission. For example, negligent care of a patient would be a violation of the principle of nonmaleficence. Although medical mistakes do occur, nonmaleficence emphasizes the commitment of healthcare providers to protect their patients from a careless and unreasonable risk of harm. When some risk of harm is inevitable, health care providers are morally bound to administer the lesser evil at the patient's discretion. It is left to the patient in such cases to determine what is considered a "lesser" or "greater" harm.²⁰ Nonmaleficence, in other words, acts as a threshold for treatment. If the harms of the treatment are greater than the benefits, according to this principle, the treatment should not be administered. For example, a patient might choose to forgo life-saving measures to avoid suffering a painful and debilitating condition because the harms of the treatment outweigh the gains of a prolonged life.²¹

Despite the principle of nonmaleficence, Black people suffer from a compromised quality of treatment due to discriminatory attitudes or practices which variously lead to misdiagnosis or improper treatment. In the book *Unequal Treatment*, a panel of experts document their evidence from a focus group with minority patients and physicians. An African American psychiatrist, for example, describes his experience with the health inequality faced by Black people: "Of course, in psychiatry we see this... Patients are inappropriately diagnosed, and medications prescribed for the patients. We see errors in that. Minority patients will often be diagnosed inappropriately as being schizophrenic."²²

²⁰ Ibid.

²¹ Roya. "Medical Ethics Explained: Non-Maleficence." *The Medic Portal*, October 20, 2016. <https://www.themedicportal.com/blog/medical-ethics-explained-non-maleficence/>.

²² Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. "Racial Disparities in Health Care: Highlights From Focus Group Findings." *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. U.S. National Library of Medicine, January 1, 1970. <https://www.ncbi.nlm.nih.gov/books/NBK220347/>.

The Harvard Medical Practice Study also found that “there were significant differences between hospitals that serve a predominantly minority population and other hospitals. That is, Blacks were more likely to be hospitalized at institutions with more adverse events (AEs) and higher rates of negligence.”²³

Such evidence suggests that Black people are not benefiting from the principle of nonmaleficence and indeed are being subjected to racist negligence by healthcare providers. The vagueness of this principle does nothing to challenge the unequal values fostered by our country’s legacy of slavery, racism, and colonialism.²⁴

Beneficence – Maximizing Patients’ Best Interests

Beneficence states that healthcare providers must do everything in their power to benefit the patient in each situation, as well as prevent and remove harm for the patient. Under this principle, all recommended treatments and procedures must be in the patient’s best interest.²⁵ A patient coming to a healthcare provider has the right to expect that their provider’s chief objective is to help them.

The ethical principle of beneficence is meant to apply not only to individual patients but also to society as a whole. Thus, healthcare providers may need to weigh the value

²³ DigitalGeorgetown Home. Harvard Medical Practice Study, January 1, 1990. <https://repository.library.georgetown.edu/handle/10822/835027>.

²⁴ Randall, V. R. “Race, Health Care and the Law,” n.d. [https://unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/603AC6BDD4C6AF8F80256B6D005788BD/\\$file/drandall.pdf](https://unrisd.org/80256B3C005BCCF9/(httpAuxPages)/603AC6BDD4C6AF8F80256B6D005788BD/$file/drandall.pdf)

²⁵ “How the Four Principles of Health Care Ethics Improve Patient Care.” online.sju, February 11, 2020. <https://online.sju.edu/graduate/masters-health-administration/resources/articles/four-principles-of-health-care-ethics-improve-patient-care>.

of different benefits in an effort to maximize overall benefits to society. Unlike nonmaleficence, which is considered to be a constant duty, beneficence is thought of as a limited duty--a moral obligation that only arises when a person becomes a patient of the healthcare provider. In other words, a healthcare provider is free to choose whom to admit into his or her practice. They do not have an obligation to benefit all persons, only those who are their patients.²⁶

This discretion on behalf of the healthcare provider can thus be exercised in a manner that discriminates based on race. Healthcare providers report, for example, that institutions mandate policies that have a significant negative impact on the provision of and access to services for racial and ethnic minority patients.²⁷ In the same focus group from *Unequal Treatment*, one African American physician recounts how, “[b]ecause [some doctors] didn't want [minority] patients, they just excluded people from certain ZIP codes, from certain sections of the city.” A person's perceived socioeconomic status based on race can also be an obstacle to obtaining quality health care services. An African American participant recounts this attitude in his experience with healthcare providers: Oftentimes, the system gets the concept of black people off the 6 o'clock news, and they treat us all the same way. Here's a guy coming in here with no insurance. He's low breed.”

As this suggests, beneficence has clear limitations insofar as it enables discrimination and thus facilitates unequal access to medical resources and care. It is not considered a

²⁶ “Principles of Bioethics.” Principles of Bioethics | UW Department of Bioethics & Humanities. Accessed September 1, 2020. <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics>.

²⁷ Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. “Racial Disparities in Health Care: Highlights From Focus Group Findings.” *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. U.S. National Library of Medicine, January 1, 1970. <https://www.ncbi.nlm.nih.gov/books/NBK220347/>.

universal obligation but rather a principle based on non-obligatory morals—ideas of altruism and humanity left to the discretion of the healthcare provider. Racist judgment on the part of healthcare providers will result in unequal medical services for the Black community. Similar to nonmaleficence, beneficence leaves racism undisturbed and clouded by unequal values that disproportionately affect Black people. Perhaps, however, the principle of beneficence can be rehabilitated in light of its concern for providing benefit to society as a whole. Through awareness and education for healthcare providers on how racism concerns society as a whole as a public health issue and a cause for chronic illness and psychological/physiological affronts, bioethicists might explicitly add race to the list of considerations of what constitutes beneficence, compelling physicians to provide equitable access to care to maximize benefits for Black communities.²⁸

Distributive Justice – Equal Outcomes

Distributive justice is defined as “the fair and appropriate distribution of benefits, risks and costs within a society.”²⁹ In the field of medical access, distributive justice has generally been interpreted as granting equal access to care for all. Distributive justice is oftentimes used to justify an individual’s right to health care. The most popular approach to distributive justice is philosopher John Rawls’ theory, which is centered around three core ideas: the equality of people in rights and liberties, the equality of opportunities for all, and the arrangement of economic inequalities that maximizes benefits for the least advantaged.³⁰ As such, distributive

²⁸ Zamina Mithani, J. Bioethics and Black Lives: A Call for Bioethics to Speak Against Racial Injustice. <https://www.thehastingscenter.org/bioethics-and-black-lives-a-call-for-bioethics-to-speak-against-racial-injustice/>

²⁹ Fisher, O., Brown, K., Coker, D., McBride, K., Steffens, D., Koh, C., & Sandroussi, C. Distributive justice during the coronavirus disease 2019 pandemic in Australia. <https://onlinelibrary.wiley.com/doi/10.1111/ans.16069>

³⁰ Wenar, Leif, "John Rawls", *The Stanford Encyclopedia of Philosophy* (Spring 2017 Edition), Edward N. Zalta (ed.). <https://plato.stanford.edu/archives/spr2017/entries/rawls/>

justice appears to hold the most promise as an ethical principle capable of addressing race-based disparities in medical treatment and resource allocation.

Rawls sees the equality of people in rights and liberties, or the guaranteeing of certain social goods, as the basis of achieving distributive justice. He calls for an index of primary goods to be created to compare members of different social groups. He lists five types of primary goods that are included: “a set of basic liberties, freedom of movement against a background of diverse opportunities, powers of prerogative and office, income and wealth, and the social bases of self-respect.”

While Rawls does not focus on shelter or health care, other bioethicists such as N. Daniels have subsequently built upon Rawls’ work and argued that the distribution of healthcare is a matter of social justice and therefore a right.³¹ Daniels argues that some basic needs are roughly equal, including having “an unpolluted environment, immunization, [and] antibiotics.”

Under Rawls’ theory, a system that allows inequality to exist should be examined to determine whether the worst off are maximally well off. As such, distributive justice has great promise in approaching racial inequality in the context of health as a means of addressing race- and income-based disparities. For instance, Shelby argues that the principle of distributive justice would require “considerable redistribution of wealth, the expansion of educational and employment opportunities and aggressive measures to address discrimination in employment, housing, and lending.” Removing such socioeconomic burdens would inherently improve health outcomes.³²

³¹ Daniels, N. 1979. “Rights to Health Care and Distributive Justice: Programmatic Worries.” *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 4(2), p.174-191.

³² Shelby, T. 2004. “Race and Social Justice: Rawlsian Considerations.” *Fordham Law Review* 72(5). p. 1697-1714.

There is still much debate amongst the bioethics community about whether the emphasis should be on equal access or on equal outcomes. While equal access, or distribution, ensures that everyone gets the same access to health care, equal outcomes attempts to achieve the goal of everyone being equally healthy. Many scholars in the field approach health disparities with equal access as the priority. For instance, Shelton writes, “the moral right to health care is best claimed in terms of equal opportunity and access.”³³ On the surface, ensuring equal access is beneficial to everyone, including communities of color and specifically Black people. After all, if we are ensuring equal access, then we are ensuring that there is equal access to health insurance, which would place initiatives like expanding Medicare or universal health care at the forefront. In addition, there would be initiatives to expand access to hospitals and health facilities in more areas, which are all objectively good.

But if we ignore outcomes in favor of focusing solely on guaranteeing equal access, existing inequalities will only be exacerbated. For instance, it should be equally important to ensure that individuals choose to use this access, especially in the field of healthcare. In the Black community, there is distrust of the health system due to historically being abused by the system.³⁴ Examples of this abuse are outlined in the introduction. So, even if everyone has equal access, if this access is not being taken advantage of because of past harms, then the issue of health disparities still remains largely unaddressed.

Focusing solely on equal access does not do enough to remedy the deep-rooted harms of racism on health care, including the high rate of comorbidities and unhealthy environments faced by Black communities. With a focus on equal outcomes, however, resources will have to be given to the worst-off communities to ensure that they achieve health outcomes on par with the best-off communities. In other words, the *social determinants* of health would

³³ Shelton, R L. 1978. “Human Rights and Distributive Justice in Health Care Delivery.” *Journal of Medical Ethics* 4(4): 165–71.

³⁴ Frakt, Austin. “Bad Medicine: The Harm That Comes From Racism.” *The New York Times*.

have to be addressed. This includes “policy interventions targeted at education and early childhood; urban planning and community development; housing; income enhancements and supplements; and employment.”³⁵ In pursuit of equal outcomes, equal access would follow as a result since more access would need to be given to underprivileged communities. Therefore, the goal and focus on distributive justice should be equal outcomes and not equal access.

Bioethical Principles during COVID-19

Bioethics comes into play during COVID-19 when, for example, the need for ventilators and ICU beds exceeds capacity. That is when doctors and hospitals must determine who gets life-saving treatments. While numerous proposals have been made to rationalize the allocation of resources with ethical justifications, the imbalance between societal and individual ethics during the pandemic has brought to light some critical ethical choices confronting healthcare providers. Bioethicists argue that during a pandemic, where everyone is at risk and no one is protected from catching the virus, ethical considerations focused on individual lives are not an effective tool for making public health policies.³⁶ Therefore, ethical principles such as nonmaleficence, beneficence, and distributive justice must be adapted as considerations to provide the greatest good for society.

Nonmaleficence

Nonmaleficence requires healthcare providers to not intentionally harm or injure their patients and serves as a threshold to determine whether the benefits of a treatment outweigh

³⁵ Thornton, Rachel L. J. et al. 2016. “Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health.” *Health Affairs* 35(8): 1416–23.

³⁶ Robert, René et al. 2020. “Ethical Dilemmas Due to the Covid-19 Pandemic.” *Annals of Intensive Care* 10(1).

the harms. Patients have the right to expect that their healthcare provider and hospital will take every reasonable measure to provide fair medical treatment. In the case of emergency situations, minimizing overall harm to society is equivalent to giving priority to the worst-off. The rule of rescue, which claims that “our moral response to the imminence of death demands that we rescue the doomed,” exemplifies this principle.³⁷ For example, transplantable livers and hearts, as well as emergency-room care, are often allocated to the sickest individuals first.

However, as indicated by our opening statistics about poorer health among Black communities a question arises concerning the nonmaleficence principle: Why are Black people still generally sicker, and why do they die earlier, than other racial groups? Priority to worst-off is broadly defined, and usually focuses on either the sickest or the youngest. Neither of these terms is race-specific. Instead, the principle of nonmaleficence generally focuses on whether the oldest, youngest, or sickest are “worst off.” Race would need to be specified as a consideration.³⁸ Preliminary research suggests that “race,” despite the established health disparities and problems, has never been one of the “worst off” factors included in the criteria for determining who gets resources.

Beneficence

Beneficence requires healthcare providers to work in their patients’ best interests. This includes the responsibility to take reasonable steps to ensure good outcomes for their patients and maximize overall utility for society, which can be interpreted as saving the most lives.

³⁷ Jonsen, Albert R. 1986. “Bentham in a Box: Technology Assessment and Health Care Allocation.” *Law, Medicine and Health Care* 14(3-4): 172–74.

³⁸ Persad, Govind, Alan Wertheimer, and Ezekiel J Emanuel. 2009. “Principles for Allocation of Scarce Medical Interventions.” *The Lancet* 373 (9661): 423–31.

Beneficence has previously motivated policies on the scarce allocation of influenza vaccines and preparedness for bioterrorism attacks.³⁹ When there is no public health emergency, the allocation of such resources would be guided by the goal of reducing overall mortality within the population. However, with scarce resources allocation, a different criterion focused on maximizing total public health benefit is recommended.⁴⁰ Therefore, during COVID-19 pandemic, approaching allocation of resources with a beneficence focus would result in giving resources to patients with the fewest comorbidities and best health in order to save the most lives. Many healthcare experts are in favor of this particular principle as the best means to maximize the benefits of limited COVID-19 resources equitably and effectively.

In hopes of maximizing benefit for the greatest number of people, the theoretical risk of “sacrificing the most vulnerable patients” will thus disproportionately affect Black communities. Black people tend to have poorer health and a higher rate of comorbidities because of systemic racism in society and more specifically healthcare. While beneficence aims for overall public health benefit, a healthcare policy that penalizes comorbidities will ultimately fail minority communities who are already much more vulnerable to COVID-19.⁴¹ As a result, this principle works as a mechanism to ensure continued discrimination against Black people, trapping Black people in the position of being forever denied access because of this vicious cause-effect circularity. Unable to get treatment due to their comorbidities and overall poorer health, Black people also have a greater rate of comorbidities due to the lack of treatment and access. In

³⁹ Ibid.

⁴⁰ Berkman, Benjamin E. 2009. “Incorporating Explicit Ethical Reasoning into Pandemic Influenza Policies.” *Journal of Contemporary Health Law and Policy* 26(1): 1–19.

⁴¹ Hick, John L. et al. 2020. “Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2.” *NAM Perspectives*.

short, the ethical principle of beneficence creates, maintains, and ensures continued inequity and awards the privileged.

Distributive Justice

Distributive justice, in theory, seems to be an ideal principle for including minorities, but preliminary research suggests that race has not been one of the criteria for defining what would entail “equal” distribution of medical resources.

Historically, the principle of distributive justice has not been applied fairly and some might argue that it has not been applied at all, especially now with the pandemic. There has been a failure to provide both health and economic resources to Black people, leading them to disproportionately experience the pre-existing conditions that lead to higher morbidity rates from COVID-19 as exhibited in Figure 3.

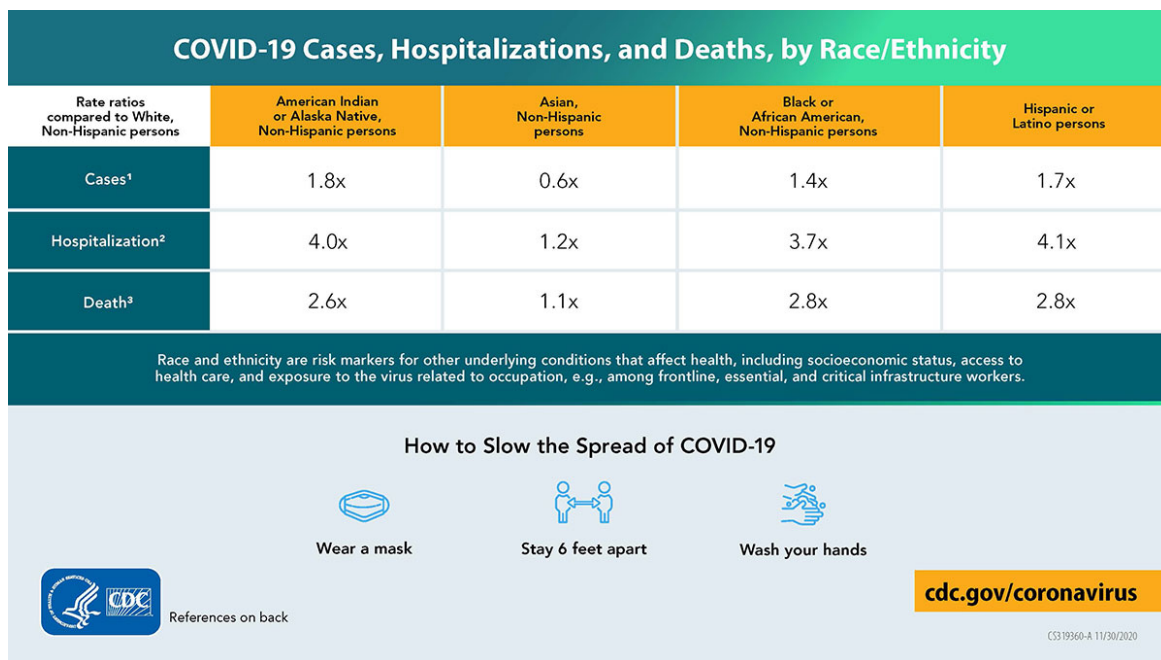


Figure 3⁴²

⁴² Center for Disease Control. (2020, November 30). *Hospitalization and death by race/ethnicity*. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>

Because of the failure to provide economic resources to Black people, and specifically, “a history of discriminatory policies around housing, land use, property rights, criminal justice, and health care,” Black people have higher rates of both homelessness and housing insecurity.⁴³ Lost wages and wealth inequality, along with COVID-19, has made it difficult for families to afford rent and bills. Black workers are overrepresented in low paying jobs and specifically the industries most impacted by COVID-19. They have less access than white workers to paid family and sick leave. As a result, workers have to choose between risking exposure by going to work while sick, or staying home and losing income. A lack of resources at every turn has hindered access to good health care, and increased exposure to coronavirus, and this is exacerbated by the increased likelihood of Black people having pre-existing conditions.

If distributive justice instead emphasizes equal outcomes, this would entail granting greater allocation of resources to Black people in order to ensure equality. If Rawls’ principles can potentially be used to address racial inequality, and thus, health disparities, then distributive justice emerges as the imperative principle in promoting equality in health outcomes of Black people and other groups.

However, presently the measurements used to dictate equality have been “race blind,” and have centered on equal access rather than equal outcomes. For instance, during the COVID-19 crisis, hospitals have been using triage scores with the aim of saving the most lives possible. One such score is the Sequential Organ Failure Assessment, or SOFA, which is used as a mortality prediction tool. While this tool appears to be an objective device for triage, it is actually biased against Black people. For instance, Black people, “compared with white people, have disproportionately greater incidence of sepsis and worse physiological effects upon

⁴³ Badger, E. (2013, August 16). The Dramatic Racial Bias of Subprime Lending During the Housing Boom. Retrieved from <https://www.bloomberg.com/news/articles/2013-08-16/the-dramatic-racial-bias-of-subprime-lending-during-the-housing-boom> AND “National Law Center on Homelessness & Poverty Racism, Homelessness, and COVID-19 Fact Sheet.” Center for Urban and Racial Equity, May 29, 2020. <https://urbanandruralequity.org/covid19equitableresponse/national-law-center-on-homelessness-poverty-racism-homelessness-and-covid-19-fact-sheet/>.

sepsis presentation.” This results in Black people having an unfavorably higher SOFA score, which negatively affects their access to treatment in the pandemic.

In short, triage scores such as SOFA reinforce and even multiply the effects of existing systemic inequalities, discouraging the allocation of resources to Black people. Distributive justice seeks to address economic inequalities that will maximize benefits for the least advantaged, but its current "race blind" method of measurement does nothing of the sort for the least advantaged at all.⁴⁴ This points up a major problem with Rawls' and others' race blind ideology. Forming an index or a measurement system without indication of race does not solve the inequalities that already exist; instead, it may have the opposite effect of reinforcing the bias.

Thus we need solutions that address equal outcomes, and not just equal access. By focusing on equal outcomes, resources will be allocated to communities in need, specifically Black people. For example, Galiatsatos et al suggest “abiding by health equity principles” that include “establishing frequent checkpoints to assess current trends in resource allocation and clinical outcomes.” This would enable the identification of health disparities, as well as whether the current allocation strategies are addressing disparities. This shifts the mode measurement toward a focus on equal outcomes. The authors also suggest that “resources provided for and outcomes of patients with COVID-19 should be reviewed on the basis of sociodemographic variables – e.g. race, ethnicity, gender, language spoken, insurance and access to health care, health literacy, census tract, and ability status.” This approach ensures a clear focus on maximizing benefits to the least advantaged that focuses on equal outcomes, rather than just equal access.⁴⁵

⁴⁴ Galiatsatos, Panagis, Allen Kachalia, Harolyn M E Belcher, Mark T Hughes, Jeffrey Kahn, Cynda H Rushton, Jose I Suarez, Lee Daugherty Biddison, and Sherita H Golden. “Health Equity and Distributive Justice Considerations in Critical Care Resource Allocation.” *The Lancet. Respiratory medicine*. Elsevier Ltd., August 2020. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7313886/>.

⁴⁵ Ibid.

Recommendations

To better serve Black communities during COVID-19, we need to allocate resources more equitably. For this reason, we are advocating that distributive justice equal outcomes approach be considered when discussing what zip codes should receive medical resources and in what amount. We also propose that beneficence should be considered when determining allocation of resources to individual patients in hospitals.

A few institutions are rethinking their current value systems and are actively including new policies that address historical injustices by allocating resources to communities more proportionately. Allocation of COVID resources that do not account for neighborhood disadvantage, especially in Black communities, may be ineffective in curbing the outbreak.⁴⁶ The Area Deprivation Index (ADI) allows for rankings of neighborhoods based on socioeconomic disadvantage on a national level.⁴⁷ Therefore, the government and healthcare systems can use ADI to target program delivery to specific geographic locations based on the greatest need and the greatest disadvantage. Given the high rate of COVID infection and mortality in black communities, ADI will facilitate the allocation of resources to them to help control and contain the outbreak. ADI is a mechanism that ensures a more ethical distribution of resources to disadvantaged communities.

⁴⁶ "Neighborhood Atlas®." Neighborhood Atlas - Home. Accessed August 15, 2020. <https://www.neighborhoodatlas.medicine.wisc.edu/>.

⁴⁷ "Area Deprivation Index." HSAG. Accessed August 15, 2020. <https://www.hsag.com/es/medicare-providers/patient-and-family-centered-care/disparities/area-deprivation-index/>

On a micro scale, when physicians are caring for individual patients, distributive justice may be impractical because at bedside individual patients are at a risk of dying and immediate decisions must be made. In such instances, we recommend that physicians apply the principle of beneficence in order to maximize the overall lives saved. Physicians should actively work in their patients' best interest, but should pay keen attention to minorities. Many healthcare experts are in favor of this particular principle as the best means to maximize the benefits of limited COVID-19 resources equitably and effectively. Instead of determining who is the worst-off in terms of ambiguous factors and individual cases, healthcare providers in such emergency situations can turn to the beneficence principle, which allows healthcare providers to rely on a simple set of metrics to determine who is most likely to survive and flourish if given the resources needed. These simple sets of metrics work because they account for an individual's greatest need and the greatest disadvantage based on their geographic location.

As we have discussed extensively, the treatment of Black patients, based on unquestioned and inherently racist principles, has been harmful. With a combination of the distributive justice equal outcomes principle on the macro level, and the beneficence principle on the micro level, we will have an expanded lens of awareness and ability to address the negative health impact historically imposed on the Black community, especially during the time of COVID-19.

Conclusion

As the disparities in health care among Black citizens become increasingly more apparent in the COVID-19 crisis, it is incumbent upon the field of bioethics and hospitals to focus on policies that center on public health rather than on individual patients.⁴⁸ This shift

⁴⁸ Berlinger, Nancy, Matthew Wynia, Tia Powell, Micah Hester, and Aimee Millikin. "Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic." The Hastings Center, March 16, 2020. <https://www.thehastingscenter.org/ethicalframeworkcovid19/>.

in approach will be challenging for healthcare professionals who are dealing with emergency conditions and scarce resources. This places new pressure on the field of bioethics to re-examine their role in the continued healthcare disparities faced by Black communities, to provide research and recommendations that are more inclusive and capable of addressing this healthcare crisis.

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