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Opinion: Racist rubric underlies COVID-19 care guidelines

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COVID-19 has laid bare a true American pathology: unapologetic, litigiously defended structural racism. We've seen it in things like "the Chinese virus," racialized policing of public masking, and white supremacists giving state capitol buildings the Rick James couch treatment without consequence. Perhaps most pernicious of all, we've seen it in deliberations pertaining to the guidelines for deciding who gets potentially life-saving treatment and who doesn't during the COVID-19 crisis.

In the event that COVID-19 cases exceed hospital capacity and exhaust supplies, those guidelines, called "crisis standards of care," help answer the difficult questions: Who gets the ventilator or ICU bed? Whose life do we save?

In Oregon, these deliberations have been held by regional committees of biomedical ethicists and care professionals from major hospital networks behind closed doors. Given Oregon's legacy of racism, there is an ethical and moral obligation to make these deliberations public—and expressly include Black, Indigenous and people of color whose communities continue to be the most severely impacted. Fortunately, Oregon can learn from what has transpired elsewhere.

Ethical guidelines recently published in Journal of the American Medical Association and New England Journal of Medicine made zero mentions of structural racism or care-provider bias. The message was clear: the authors did not see racism as relevant to ethical analyses of health care triage and rationing. In their attempt to outline an ethical path, they arrived in the middle of colorblind boulevard—crafting principles they believed were fair because they make no considerations of "race."

Perhaps impelled by these publications, some states, such as Massachusetts, published guidelines that also failed to consider structural racism and provider bias. After critical resistance from community groups and health professionals raising equity concerns, Massachusetts revised its guidelines.

So where is Oregon in this?

As members of Multnomah County's Public Health Advisory Board, we've had the opportunity to engage in some early conversations pertaining to Oregon's "crisis care guidance." Some of us have been privy to the deliberations unfolding privately. Here's what we've learned.

Like other states, in the event of a crisis overwhelming hospitals, Oregon's guidelines call for prioritizing patients based on their chances for survival. It considers two components. The first is a patient's "hospital survival" (will the patient survive to leave the hospital), as measured by organ function tests. The second is a patient's "near-term" survival (how long a patient might survive once discharged), which factors in pre-existing conditions like diabetes, heart disease and respiratory disease.

Like Massachusetts, Oregon's guidelines expressly bar considerations of gender, race, religion and other protected classes in triage decision-making to prevent discriminatory application of the rubric. However, as a coalition of groups detailed in a letter to Oregon Gov. Kate Brown, the scoring system penalizes people with pre-existing conditions. Because of systemic racism embedded in core health-related facets of life, like housing, employment opportunities, and food environments, most of these conditions are more prevalent within communities of color—meaning communities of color will be scored lower by design.

Moreover, communities of color are already at greater risk of COVID-19 exposure due to the racially-skewed nature of employment patterns in frontline industries. For example, Latinx make up 53% of farmworkers and 27% of food service workers. People of color account for 65% of Amazon workers, and a disproportionate percentage of licensed practical nurses, public transit workers, and cleaning service workers. This is the sum of quintessential American racism: communities of color simultaneously deemed essential and expendable.

Under these conditions, "equally" applying a colorblind care rubric is not an act of fairness—it's an act of unapologetic, litigiously obfuscated structural racism. The rubric is de facto racism cloaked in de jure innocence.

Oregon must do better. Failure to change will be to commit an act of racialized public health violence: systematically choosing white lives over Black, brown, and Indigenous ones. To avoid this, regional ethics committees should immediately open dialogue with leadership from BIPOC-led organizations across Oregon and extend committee membership. And BIPOC organizational leaders must call upon these committees to reconvene the 30+ hospital networks that approved current guidelines and craft a revised rubric rooted in an anti-racist framework that explicitly considers structural racism's impacts on pre-existing conditions. Additionally, the governor and the Oregon Health Authority must support these efforts—silence on this matter obfuscates roles and responsibility, and thus accountability.

As calls for reopening and returning to "normal" grow, we must remember whose lives are most at stake. We have an opportunity to craft guidance that reflects a more robust commitment to racial and health equity. It is an opportunity to reimagine, not return to, "normal": because the social distance of normal kills—some of us more than others. And we'll be damned if we let a rationing rubric put a mask on that.

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