

The Endless Looping of Public Health and Scientific Racism

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SUMMARY. There is a new intensity to the way that race, racism, and health risk have been jockeying for headlines. Given a global pandemic and a federal administration desperate to salvage its reelection prospects, questions of distributive justice—from vaccines to ventilators to triage—have become vexed by some truly terrible ideas. This essay is a call to avoid injecting terrible old ideas back into public policy practice in ways that threaten to instantiate whole new regimes of discrimination, segregation and “race science.”

Introduction

We were in first grade together, the woman who used to call me her Best Black Friend. I cured her of that years later, but still, after a lifetime of valiant trying on both our parts, she retains the power to startle. There we were, having a perfectly amiable chat about actor James Earl Jones’s lusciously resonant baritone when she said: “it must be because of the way black people’s larynxes are shaped. You can hear the difference in the how their vocal cords affect sound.” I was so taken aback by her sudden slippage into an imaginary plural that I could not speak. She saw that I was struggling. “It’s probably why you have such a beautiful voice,” she added gently, as though application of the aggregate singular might help.

There are many absurd assumptions about embodied black difference abroad in our land: “They” can’t swim because their bodies don’t float. “They” can jump higher thanks to an extra muscle in their legs. The imagined black body has a smaller brain, a bigger butt, a longer penis, saltier blood, wider feet, extra genes for aggression, thicker skin. Nor is this just history. Many dangerously unscientific beliefs about racial difference are baked into present-day pharmaceutical titrations and point-based algorithmic calculations, altering diagnoses of everything from incidence of skin cancer, to diabetes, to likelihood of osteoporosis, to tolerance for pain.

It is thus that I greet with great suspicion the news that a federal committee advising the Centers for Disease Control and Prevention (CDC) is reported to be considering who should be at the head of the line for any vaccine developed for COVID-19; and that one idea being floated is whether those identified as black and Latinx should be prioritized as distinguishably COVID-19-vulnerable populations (Twohey, 2020).

There’s no question that people of color are dying at disproportionately unholy rates. As of mid-summer 2020, the age-adjusted data analyzed by the American Public Media Research Lab, indicates that the widest disparities in American deaths afflict

black, indigenous and Latinx populations. Black mortality rates are from 2.3 to 3.7 times greater than for whites. Indigenous rates are as much as 3.5 times higher and Latinx people two to three times higher (APM Research Lab, 2020). When broken down by county, the death rate for predominantly black counties is six times that of predominantly white counties. But all racial groups marked as minorities in America—including Asians, Latinos, Pacific Islanders—are more likely than whites to die from COVID-19 (APM Research Lab, 2020). And the true picture may actually be much worse: CDC weights its calculations in ways that omit geographies that have few to zero cases—which, coincidentally, just happen to be largely white areas. According to an article in the *Journal of the American Medical Association*, this weighted counting “understates COVID-19 mortality among Black, Latinx, and Asian individuals and overstates the burden among White individuals” (Cowger et al., 2020).

The problem with assigning vaccine-eligibility by race or ethnicity centers on the use of those political and social constructs as proxies for all the prejudices and vexed material conditions that render raced bodies as more susceptible to begin with. In effect, it turns “race” into a signifier of innate disease propensity and physical disability. Yet, one may wonder why minorities’ lower survival rates could not be more accurately described by referring to homelessness, dense housing, lack of health insurance, inadequate food supplies, or exposure to environmental toxins in the ghettoized geographies that have become such petri dishes of contagion.

This is not to suggest that discrimination suffered by blacks and Latinx is simply about class. In a nation shadowed by eugenic intuitions about “useless eaters” whose lives are deemed “not worth living,” race is its own risk. American prejudices about color and race are rooted in powerful, long-term traditions of anti-miscegenation and untouchability: the propinquity of dark bodies—sometimes even so much as eye contact—incites anxiety and a fear of social contamination. Even to doctors, color can be an unacknowledged source of revulsion if they have grown up in

all-white environments; it can operate affectively and aversively, like stigmatizing witchery. It's understandable why head-of-the-line vaccinations might be attractive to some, if only as a devil's bargain offering access to a resource perceived as otherwise inaccessible to blacks and Latinx.

There are surely no easy answers to managing scarce resources in dealing with a disease whose tragic boundlessness is still revealing itself.

Still, I worry about building public health architectures that use race or ethnicity as the equivalent of innate, biologized vulnerability—or, for that matter, biologized invulnerability. There is already global panic about who of us will live or die. One might anticipate vaccine eligibility-by-race turning into an unseemly competition over “blood.” How precisely would race even be determined: how you look? Who you grew up with? Would ethnicity be determined by your name? Your neighborhood? Would the whole thing end up being an economic boondoggle for sketchy DNA testing companies?

It can be simply insidious to think of “race” as proxy: looking at someone's color or social “place” and presuming all sorts of medical, criminological and genetic predispositions is unscientific. By the same token, looking at a genetic variation and naming it after a more capacious, capricious and/or unstable category like “Hispanic” or “native American” is to write culture onto genes. (This is precisely how 23andMe and other ancestry-tracking or direct-to-consumer companies seem to be rewriting race as biological. They are thoughtlessly mapping all the social baggage of race onto the genome. It might not sell as well to those who are looking for romantic reconnection with lost “roots,” but it would be a lot safer and saner and more scientific to use an entirely new or different symbolic vocabulary to mark allelic or haplotype groupings.) To reinscribe the convoluted, shape-shifting social baggage of racial division onto our biology actually creates a new golem, a doppelganger of what we have historically thought of as race but a version that marks difference even more efficiently and insidiously than its older instantiations.

As far as we know, all humans are vulnerable to COVID-19. To assign race as causal in its spread is a category mistake. Even where certain diseases actually do cluster within particular populations, it is a mistake to describe such clusters as racial. Conditions like enzyme deficiencies, tolerance for altitude, the ability to metabolize certain proteins or construct nucleic acids, or the susceptibility to certain diseases are distributed throughout our species. Humans are susceptible to a whole range of diseases we often delude ourselves into thinking of as the property of “only” particular ethnicities or races, such as Tay-Sachs among descendants of Ashkenazi Jews; Kawasaki Disease as having a somewhat higher frequency among Japanese descendants; or sickle-cell anemia, often misleadingly called a “black” disease rather than an equatorial or malaria-related disease; or skin cancer which I once heard a television doctor describe as something black people “never” have to worry about. (I guess he never heard of Bob Marley.)

All this shows that even high aggregations of frequency are no substitute for actual diagnoses: mere correlation is not the same as cause and effect. Yet, epidemiological calculations are

too-frequently used as proxies for individual diagnoses, such as osteoporosis. For example, websites such as Medscape assign race in order to calculate one's risk of breaking a bone (Medscape, 2020).

Yet, while less melanin (or lighter skin) is correlated with higher risk of osteoporosis, racial identity is not biologically revealing of melanin (or diet or exercise, also indicators of risk): it is a political designation, whose parameters vary from nation to nation and culture to culture. Those who are assigned whiteness can run a gamut of skin tones; and among those perceived as black there is a degree of variety as broad as humanity itself. A very light-skinned “black” American might be as prone to osteoporosis as a blonde woman from Norway. Moreover, even the very question of race is not one that is asked universally, but mainly in American-derived calculations. The website FRAX, an internationally used calculator formulated in the United Kingdom, has a calculator specifically for “USA use only,” which distinguishes risk for “US (Caucasian)” from “Black,” “Hispanic,” and “Asian” (FRAX, 2020).

To push the point just a little more, I am a woman of “a certain age” and doctors routinely use those two metrics—age and sex—as triggers for testing women over the age of 60 for osteopenia or osteoporosis. Thus, when I was given a routine bone scan recently, the results that came back to a computer on my doctor's desk were supposed to figure out whether I might need medication, using my individual data and predictive algorithms. The doctor sat behind his computer screen for a very long time. Finally, his head emerged from around the rim of the screen. He cleared his throat, and mumbled that the machine couldn't do the calculation, “probably because you're black.” Annoyed but undaunted, I told him just to sabotage that machine by telling it I was white. Based on that simple switch of identity alone, the system promptly presented me with a slew of additional questions: like whether I'd ever broken a bone, if so at what age, whether I showed signs of rheumatoid arthritis, and most urgently, whether there was osteoporosis in my family, especially my mother.

The fact that the machine would not have asked me any of that if I had been categorized as black was machine-bias of a profound and profoundly interesting sort. Indeed, although the machine apparently had categorized my black-ness as “self-identified,” no one asked me about my heritage. Clearly some administrator or nurse had checked the box based on how purportedly and persistently “self-evident” or “obvious” race is thought to be within the American cultural context.

The infinite spectrum of melanin inheritance is thus reductively “seen” as an “either-or.” In addition, the authority of my well-trained doctor, a human expert, was superseded by the narrow closed-loop small-mindedness of a black box containing only the pathways programmed by a non-medical computer scientist who was apparently socialized to think about race as binary and blinding. The deference my doctor accorded to the machine—and the deference most of us accord algorithms—dislocates particularized human expertise. Black box medicine may be great at identifying and assessing broad patterns, but when it comes to the peculiarly complex intricacies of individual bodies in a nation of extraordinarily mixed and diasporic heritage, that deference to

the machine can effectively end up treating probabilities as though they were certainties or absolutes. In or out; all or nothing.

Thus, varying organic presentations of disease as well as adaptations to varying ecological conditions (like famine, altitude or inbreeding) are best thought of as precisely that: variations on a common human theme.

And yet, to this day, American medical schools teach that African Americans have greater muscle mass than whites. This is a fiction that dates to slavery, yet it informs how kidney disease is treated, for creatinine levels are used to measure kidney function, and greater muscularity can increase the release of creatinine in blood (Epstein et al., 2000). But rather than assessing individual patients' actual muscle mass, most hospitals rely on an algorithm that automatically lowers black patients' scores thus delaying treatment in some instances by making all black people appear healthier than they may be (Roberts, 2020).

Similarly, a test developed and endorsed by the American Heart Association (AHA) weighs race in determining risk of heart failure: the algorithm automatically assigns three extra points to any "nonblack" patient; the higher the score, the greater the likelihood of being referred to a cardiology unit. Yet, there is no rationale for making race a lesser risk factor in heart disease and the AHA provides no reason (Vyas et al., 2020). Needless to say, black and Latinx patients with the same symptoms as their white counterparts end up being referred for specialized care much less often (Vyas et al., 2020).

Underserved, too many black patients go unnoticed till they are at death's door with "sudden" or "aggressive" versions of common diseases. With endless irony, that is when those neglected bodies may become exceptionalized embodiments of "genetic difference." Medical historians like Harriet Washington, Dorothy Roberts, Lundy Braun, Troy Duster and Evelyn Hammonds have been complaining about such stereotypes and biases for decades, but perhaps it has taken the convergence of #BlackLivesMatters, a global health crisis, and a diverse new generation of outspoken medical personnel for this topic to have finally been taken seriously (Rosenbaum et al., 2020).

Rationing Care During the Pandemic

Again, I raise these stereotypes in order to ponder the medical consequence of such epistemic foolishness at a moment when COVID-19's disparate toll on black and brown bodies has directed much attention to "underlying conditions." Careful commentators will point out that underlying conditions are not the same as innate predisposition: there is no known human immunity to this coronavirus. And while age and illness may diminish our immune system's response to any pathogen, that greater susceptibility is merely a probability indicative of neither any human predisposition nor any natural immunity. Our universal susceptibility to it is underscored precisely by the virus' being "novel." It bears repeating that underlying conditions like rates of stress, diabetes, asthma, and crowded living conditions and overrepresentation in risky jobs are factors directly accounting for greater intensity of affliction. We know this—this is not a mystery.

Given this, attention to the fate of people of color is both overdue and double-edged: it highlights inequities but also risks reinforcing them as innate. For example, if the United States' rates of infection are wildly off the charts compared to other nations, we do not generally blame it on the innate conditions of a peculiarly "American" biology; we know these numbers are the product of poor policy decisions. Just so, disproportionate deaths among communities of color must not be attributed to an imagined separateness of "African American" biology. Yet, that is precisely the risk!

Amid a welter of misguided fantasies of "sub-species," "bad blood," and dissolute traits, we forget at our peril that the trauma and social factors disproportionately affecting people of color are also driving death rates among whites—if not to the same degree. Trap white people in crowded, poisoned, impoverished contexts and they die too.

The proposal to use race or ethnicity as a marker of disease vulnerability performs its persuasive labor by appealing to life-saving potential where confined to the context of vaccine prioritization. But it remains to be seen how race will intersect with the usages of vulnerability for purposes of triage in hospital settings. COVID-19 reduces us all to frail, wheezing, non-essential, bare bodies. When we arrive at the emergency room, we are delivered as mere bags of bones among so many "burdening" the health care system. Anonymously quarantined in isolated wards, not visibly marked as a uniquely beloved soul with dear family and networks of friends—is bad enough without having race deployed as an additional cipher for poor outcome. With a shortage of ICU beds, such a cipher will likely be algorithmically weighted as well, for algorithms are more efficient than the Horae, and doctors are really quite busy these days.

Recognizing the risks of bias in such emergency circumstances, the Department of Health and Human Services' Office of Civil Rights issued a bulletin on March 28, 2020, restating a federal commitment to protecting "the equal dignity of every human life from ruthless utilitarianism." Under both the Americans with Disabilities Act and the Affordable Care Act, people "should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities or age." The underlying concern is exemplified by the case of Michael Hickson, a black quadriplegic whose COVID-19 care was withdrawn by St. David's South Austin Medical Center after a doctor told his wife: "...his quality of life—he doesn't have much of one." His wife was recorded asking pointedly: "Because he's paralyzed with a brain injury, he doesn't have quality of life?" The doctor answered in the affirmative (Shapiro, 2020).

The New England Journal of Medicine has run a number of articles about triage in the face of shortages of ventilators. Here is one such take:

Triage proceeds in three steps: 1. application of exclusion criteria, such as irreversible shock; 2. assessment of mortality risk using the Sequential Organ Failure Assessment (SOFA) score, to determine priority for initiating ventilation; and 3.

repeat assessments over time, such that patients whose condition is not improving are removed from the ventilator to make it available for another patient. (Shapiro, 2020).

Number one covers the direst instances—crudely put, those who do not stand a chance. Number two, mortality risk, may encompass a lot of us who are older or who have disabilities or other pre-existing conditions. And since there is overlap between long-term stress, environmental poisoning, poverty, lack of medical insurance and such conditions, there is quite a perfect storm of collective mortality risk clustered by zip code and histories of real estate segregation.

Number three, “repeat assessment” of whether to free life support for another patient is interpellated by availability of resources that will be in shorter and shorter supply as the numbers of sick and dying continue to climb. Ideally, such assessment is supposed to be done by committee, in conversation with family members or surrogates, and done with consideration of a patient’s Do Not Resuscitate orders.

But, in a pandemic or other emergency, decisions to withdraw care are frequently up to a single doctor or resident or perhaps a nurse. In other words, given the mounting numbers, it will probably be up to a highly stressed, overworked, frightened, sleep-deprived human being who has no relation to you but the abstractions of your temperature, oxygenation rate, age, and whatever else that singular individual medical professional finds to read onto, into, or out of one’s body.

Discrimination against those with loosely defined disabilities is already quite common; the University of Washington Medical Center, for example, has argued for “weighing the survival of young, otherwise-healthy patients more heavily than that of older, chronically debilitated patients” (Ne’eman, 2020). The reconfigured overlay of race as itself a debilitating, resource-consuming morbidity-risk worsens the situation. Disability rights advocates have worked hard to push these concerns to the front burner, urging Congress to ban triage based on “anticipated or demonstrated resource-intensity needs, the relative survival probabilities of patients deemed likely to benefit from medical treatment, and assessments of pre- or post-treatment quality of life” (Solomon et al., 2020; see also Chapter 34). On July 22, the advocacy organization Disability Rights Texas filed a complaint with HHS against the North Central Texas Trauma Regional Advisory Council for its use of a rigid, point-based, algorithmic scoring system, which can automatically exclude from intensive care persons with a range of pre-existing conditions and disabilities without resort to individual assessment. Other states are beginning to reexamine their crisis rules in response to such concerns.

Political Consequences of Treating Race as Biological Destiny

Perceptions of disease, deviance, and disgust have always enabled time-worn and hypnotic constructions of embodied difference to be carried forward. When *The New Yorker Magazine* chose “The Black Plague” as a title for a really excellent piece about COVID-19 by the very insightful author Keeanga-Yahmahtta Taylor, there

was a some pushback and rethinking of that as an unfortunate choice allowing some to think of the disease as not really affecting young white people partying on Florida beaches. More obviously and more powerfully, when Donald Trump speaks of “the China virus,” he not only gives the disease a race and a place; true to his outsized colonial imagination, he gives it distance. It’s “over there,” not here, well removed from the conceptual possibility of “our” susceptibility. If “we” are afflicted, it is not just the illness that debilitates us but anger that we have been invaded by “them.” It is this form of displaced animus that one saw in the spikes of anti-Asian prejudice that arose in the wake of outbreaks of smallpox in San Francisco’s Chinatown in the 1800’s and that culminated in the Chinese Exclusion Act of 1882. Anti-Semitic nativism targeted Jews after bouts of typhus in 1892 (Wald, 2008). Mary Mallon, or “Typhoid Mary,” was an asymptomatic carrier of typhoid fever; her arrest in 1907 on public health charges galvanized much anti-Irish sentiment in New York City, figuring them as immigrants importing unsanitary and slovenly habits (Wald, 2008; Schweik, 2009). When the AIDS epidemic first started spreading in the 1980’s, some people told themselves it was a disease conveniently localized to the bodies of “gay men.” And when Zika virus was carried from equatorial regions by mosquitos riding the waves of climate change, New York City health officials sprayed insecticide by zip code (focusing on East Flatbush, Bed-Stuy, Crown Heights and Brownsville in Brooklyn, and in upper Manhattan, in the neighborhood once known as “Spanish Harlem”) (Frishberg, 2016), as though those pesky identity-politicking mosquitos could simply be red-lined (Denis, 2020).

Instead of coming together around our shared vulnerability, time and again we have created a set of golems to stand in for a pathogen, divisive demons that direct our fears of inherent virulence, murderous voraciousness and leech-like parasitism. Asians. “Aliens.” Anarchists. Reporters. Media. Social media. Dr. Fauci. The state of California. The city of Chicago. “That woman,” who is the governor of Michigan. People who wear masks. People who don’t wear masks. Peaceful demonstrators transformed into the face of “Corona Violence.” It is not by accident that President Trump’s targeted ads to white suburban housewives so neatly suture race, riot and disease as a way to channel the existential fear to which we are all so vulnerable right now: if you can keep “them” out of your neighborhood, everything is going to be all right.

Americans are not raised to believe in the entanglements of a common fate. The very notion of public health has been undermined by ingrained brands of individualism so radical that even contagious disease is officially regulated by the vocabulary of “choice,” “freedom” and “personal responsibility.” Many of us live in bubbles of belief that conceptual walls will protect us from things that are not easily walled: guns will bring peace, housing discrimination will bring bliss to soccer moms, segregated schools will serve up stable geniuses, and owning an island in the Florida keys will seal us off from child molesters, mafia dons and domestic abuse.

These comforting bromides set us up for naïve beliefs that disease invariably marks bodies in visible ways. “Surely we’ll be able to see it coming.” “You’re fine if don’t have a fever.” “You can’t spread it if you’re not coughing.” “You won’t give it to anyone if you’re

asymptomatic.” Well before this pandemic, we Americans were blinded by the walls of our privatized bunkers, yet the sense of entitlement which supposes that disaster will strike “over there” but “not in my backyard” pretty much guarantees an amplification of misdirected resources and relative disparities from which everyone will suffer eventually.

Conclusion

I have no answer for the deeply divisive fissures of race, ethnicity and American political identity that COVID-19 has exacerbated, although I truly wish I could think my way to a happy ending. So, I read and study and reread those statistics about how ethnic minorities, blacks, black women are dying at higher rates. I am not an epidemiological statistic—yet I have no doubt that my body will be read against that set of abstracted data points. I, and we all, will be read as the lowest common denominator of our risk profiles at this particular moment. Not only are we no longer a “we,” I am no longer an “I” in the time of coronavirus.

Meanwhile, COVID-19 makes snacks of us. The fact that there may be variations in death rates based on age or exposure or pre-existing immunological compromise should not obscure the epidemiological bottom line of its lethality. It kills infants, it kills teenagers, it kills centenarians. It kills rich and poor, black and white, overworked doctors and buff triathletes, police and prisoners, fathers and mothers, Democrats and Republicans. We can divide ourselves up into races and castes and neighborhoods and nations all we like, but to the virus—if not, alas, to us—we are one glorious, shimmering, and singular species.

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