

LEGALITY OF EXPLICIT RACIAL DISCRIMINATION IN THE DISTRIBUTION OF LIFESAVING COVID-19 TREATMENTS

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ABSTRACT

In 2021, the Federal Drug Administration released a statement advocating for race and ethnicity to be used in rationing lifesaving COVID-19 treatments. By January 2022, three states had implemented policies explicitly prioritizing treatments based on race, which resulted in multiple legal challenges. This Article analyzes the uphill battle such policies would face in an equal protection challenge. It also rebuts the attempt to analogize these policies to the legally acceptable practice of racial preferences in college admissions. Finally, nonlegal, pragmatic consequences are considered, such as how the policy risks disproportionately favoring the wealthy reduces trust in future government pronouncements regarding COVID-19, perpetuates harmful stereotypes about racial inferiority, breeds racial resentment, and causes unnecessary delays in treatment.

The racially disparate outcomes from the COVID-19 pandemic illuminate numerous background factors that disadvantage minority groups. However, the implementation of racial preferences in lifesaving treatments is not the answer. As demonstrated in this Article, such policies spectacularly fail judicial scrutiny. Furthermore, the nonlegal, pragmatic considerations establish that such a policy does far more harm than good. These considerations are of paramount importance not only for the current COVID-19 crisis but also for future pandemics and the rationing of other limited medical resources, such as organ transplants and intensive care unit beds.

I. INTRODUCTION

COVID-19 has elicited a variety of issues regarding race and the law. When the vaccine was first made available, the Centers for Disease Control and Prevention (“CDC”) and various medical experts advocated for explicit racial preferences in distribution.¹ Heightened skepticism toward vaccination in the Black and Hispanic communities was linked to past racial discrimination in medicine, such as the Tuskegee Syphilis Study.² This vaccine skepticism results in disparate enrollment rates in COVID-19 vaccine trials, which in turn results in more skepticism in the Black community as to the safety of the vaccine for Black

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1. Michael Conklin, *Racial Preferences in COVID-19 Vaccination: Legal and Practical Implications*, 5 HOW. HUM. & C.R. L. REV. 141, 150-52 (2021).

2. Dezimey Kum, *Fueled by a History of Mistreatment, Black Americans Distrust the New COVID-19 Vaccines*, TIME (Dec. 28, 2020, 8:30 AM), <https://time.com/5925074/black-americans-covid-19-vaccine-distrust/> [<https://perma.cc/9UNW-D83B>].

people.³ Blacks and Hispanics are more likely to have comorbidities that increase the risk of hospitalization and death from COVID-19, such as obesity⁴ and chronic kidney disease.⁵ Compounding the issue is that there are inequalities in access to nutritious foods⁶ and health care.⁷ Early ventilator shortages were particularly significant in minority communities because the Sequential Organ Failure Assessment scale used to determine access to ventilators disadvantaged minority patients.⁸ New York City was criticized for prioritizing some races over others in distributing COVID-19 tests.⁹ Blacks and Hispanics are more likely to work in the service industry, where they are more vulnerable to COVID-19.¹⁰ Blacks and Hispanics are more likely to live in multigenerational homes, which increases the risk of COVID-19 transmission.¹¹ Due to lower vaccination rates, vaccine mandates were criticized for disproportionately harming Blacks and Hispanics.¹² Race and gender preferences in President Biden's \$1.9 trillion

3. Ada Stewart, *Minorities Are Underrepresented in Clinical Trials*, AM. ACAD. FAM. PHYSICIANS (Dec. 4, 2018), <https://www.aafp.org/news/blogs/leadervoices/entry/20181204iv-clinicaltrials.html> [<https://perma.cc/3GU7-W5WK>].

4. Ruth Peterson et al., *Racial and Ethnic Disparities in Adult Obesity in the United States: CDC's Tracking to Inform State and Local Action*, 16 PREVENTING CHRONIC DISEASE E46, E46 (2019).

5. *Race, Ethnicity, & Kidney Disease*, NAT'L KIDNEY FOUND., <https://www.kidney.org/atoz/content/minorities-KD> [<https://perma.cc/QFT3-3RPJ>] (last visited Jan. 21, 2022).

6. Kelly Brooks, *Research Shows Food Deserts More Abundant in Minority Neighborhoods*, JOHNS HOPKINS MAG. (Spring 2014), <https://hub.jhu.edu/magazine/2014/spring/racial-food-deserts/> [<https://perma.cc/D5JZ-72SW>].

7. Jesse C. Baumgartner et al., *Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts*, COMMONWEALTH FUND (June 3, 2021), <https://www.commonwealthfund.org/publications/2021/jun/inequities-health-care-black-latinx-hispanic-communities-23-charts> [<https://perma.cc/D89C-M3EM>].

8. Michael Menconi, *COVID-19 Ventilator Allocation Protocols Are Poised to Disadvantage African Americans*, VOICES BIOETHICS (May 30, 2020), <https://journals.library.columbia.edu/index.php/bioethics/article/view/6210> [<https://perma.cc/D5CR-WQQ4>].

9. Jon Levine & Conor Skelding, *NYC Admits Prioritizing Race in Distributing COVID Tests: Leaked Emails*, N.Y. POST (Jan. 1, 2022, 11:30 AM), <https://nypost.com/2022/01/01/nyc-admits-to-prioritizing-race-in-distributing-covid-tests/> [<https://perma.cc/7MQ4-MTW2>].

10. Lisa DuBay et al., *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and Their Families*, URBAN INST. (Dec. 2020), <https://www.urban.org/sites/default/files/publication/103278/how-risk-of-exposure-to-the-coronavirus-at-work-varies.pdf> [<https://perma.cc/4YAL-D46A>].

11. April Simpson et al., *One Home, Many Generations: States Addressing Covid Risk Among Families*, NBC NEWS (Mar. 27, 2021), <https://www.nbcnews.com/news/latino/latino-multigenerational-households-risk-covid-states-address-vaccine-rcna511> [<https://perma.cc/FTG4-FDYC>].

12. Jonathan Tobin, *Vaccine Mandates Will Have a Disparate Impact on Minorities*, NEWSWEEK (Aug. 17, 2021, 7:00 AM), <https://www.newsweek.com/vaccine-mandates-will-have-disparate-impact-minorities-opinion-1619755> [<https://perma.cc/5N6Q-4ZSU>].

American Rescue Plan Act were enjoined by the Sixth Circuit Court of Appeals.¹³

The availability of highly effective COVID-19 treatments in late 2021 introduced another legal race issue, namely, the constitutionality of rationing such life-saving treatments in a racially discriminatory manner. The Federal Drug Administration (“FDA”) released a statement explicitly advocating for race and ethnicity to be considered in administering COVID-19 treatments.¹⁴ New York,¹⁵ Utah,¹⁶ and Minnesota¹⁷ implemented policies that explicitly discriminate on the basis of race in rationing COVID-19 treatments. A number of people challenged the legality of these policies. Senator Marco Rubio sent a letter to the FDA referring to the policy as “racist and un-American.”¹⁸ Former Trump advisor Stephen Miller’s organization, America First Legal, filed a lawsuit against New York, referring to the policy as “racist fascism.”¹⁹ Cornell law professor William A. Jacobson filed a class action lawsuit as the named plaintiff against the New York State Department of Health.²⁰ This Article analyzes the uphill battle such

13. See *Vitolo v. Guzman*, 999 F.3d 353 (6th Cir. 2021).

14. Alejandra O’Connell-Domenech, *FDA Urges Race, Ethnicity Be Considered in COVID-19 Drug Treatment*, HILL (Jan. 10, 2022), <https://thehill.com/changing-america/well-being/prevention-cures/589079-fda-urges-race-and-ethnicity-be-considered-in> [https://perma.cc/P8C4-EBN6].

15. Houston Keene, *New York Says It Will Prioritize Non-White People in Distributing Low Supply of COVID-19 Treatments*, FOX NEWS (Dec. 31, 2021, 2:30 PM), <https://www.foxnews.com/politics/new-york-prioritize-non-white-people-low-supply-of-covid-19-treatments> [https://perma.cc/6JTX-83EQ].

16. Simone Seikaly, *Utah Health Officials on State’s Covid Risk Score Calculator: Race/Ethnicity Isn’t Automatic Qualifier*, KSL NEWS RADIO (Jan. 11, 2022, 8:21 PM), <https://kslnnewsradio.com/1962481/utah-health-officials-on-states-covid-risk-score-calculator-race-ethnicity-isnt-automatic-qualifier/> [https://perma.cc/2DLN-GCN8].

17. Eugene Volokh, *Minnesota Government: “Deprioritiz[e] Access for Patients” to COVID Drugs, Based Partly on Their Being White*, REASON (Jan. 3, 2022, 12:25 AM), <https://reason.com/volokh/2022/01/03/minnesota-government-deprioritize-access-for-patients-to-covid-drugs-based-partly-on-their-being-white/> [https://perma.cc/2UTU-V333] (Minnesota has since removed the racial component in its latest draft); Jeremy Olson, *Minnesota Removes Race as Factor in Rationing COVID-19 Antibody Treatment*, STAR TRIB. (Jan. 13, 2022, 12:27 PM), <https://www.startribune.com/minnesota-removes-race-as-factor-in-rationing-covid-19-antibodies/600135503/> [https://perma.cc/826D-HW4M].

18. Press Release, U.S. Senator Marco Rubio, Rubio to FDA: Un-American to Ration Life-Saving COVID Treatments Based on Race (Jan. 11, 2022), <https://www.rubio.senate.gov/public/index.cfm/2022/1/rubio-to-fda-un-american-to-ration-life-saving-covid-treatments-based-on-race> [https://perma.cc/JD9X-3CSM].

19. Yael Halon, *Former Trump Advisor Suing New York State for Racialized Coronavirus Priorities: ‘This Is Racist Fascism,’* FOX NEWS (Jan. 4, 2022, 10:31 PM), <https://www.foxnews.com/media/stephen-miller-suing-new-york-racialized-coronavirus-priorities> [https://perma.cc/V5H9-B93H].

20. Samuel Kim, *Cornell Law Professor Sues to Stop State’s Discriminatory Therapeutic Guidelines*, CORNELL REV. (Jan. 18, 2022), <https://www.thecornellreview.org/cornell-law->

policies would face in an equal protection challenge. It also rebuts any attempt to analogize the policy with the legally acceptable practice of racial preferences in college admissions. Finally, pragmatic aspects are considered as to the wisdom of such policies.

II. THE POLICIES

In the Utah plan, points are awarded for 14 risk factors.²¹ Vaccinated people must score 10 or more, and unvaccinated people must score 7.5 or more to qualify for treatment.²² The policy assigns twice as many points for being any race other than non-Hispanic white than for high-risk comorbidities such as hypertension, congestive heart failure, and cardiac arrhythmia.²³ And being of any race other than non-Hispanic white is awarded the same points as being morbidly obese or severely immunocompromised.²⁴

Minnesota implemented a similar points system under which “BIPOC status”²⁵ is awarded two points which is the same amount awarded for someone 90 years old or morbidly obese.²⁶ In the New York plan, patients are required to “have a medical condition or other factors that increase their risk for severe illness” to be eligible.²⁷ Anyone who is not a non-Hispanic white person is automatically considered to meet this requirement.²⁸

The lack of consistency among these plans may demonstrate the lack of scientific evidence that went into the formulas. For example, in Minnesota chronic kidney disease is awarded three points, which is 50% more than one receives from being morbidly obese.²⁹ But in the Utah plan, chronic kidney disease is only awarded one point, which is 50% less than one receives from being morbidly obese.

None of these policies create an absolute bar to non-Hispanic whites receiving lifesaving COVID-19 treatments. And the Utah and Minnesota policies do not automatically give treatments to someone based solely on his or her race.³⁰

professor-sues-to-stop-state-therapeutic-guidelines/ [https://perma.cc/L6JS-SBSG].

21. Seikaly, *supra* note 16.

22. *Id.*

23. *Id.*

24. *Id.*

25. “BIPOC” stands for “Black, Indigenous and other people of color.” Volokh, *supra* note 17.

26. *Id.* Minnesota has since removed the racial component in its latest draft. Olson, *supra* note 17.

27. Keene, *supra* note 15.

28. *Id.*

29. Volokh, *supra* note 17.

30. The New York policy does give automatic treatment to everyone who is not a non-Hispanic white, assuming they are at least 18 years old, test positive for COVID-19, and are able to start treatment within five days of the onset of symptoms. *See* Memorandum from the New York State Dep’t of Health to Health Care Providers and Health Care Facilities (Dec. 27, 2021),

However, they each create racial hierarchies in which a non-Hispanic white patient would be denied treatment, while a similarly situated minority patient would be given treatment. Furthermore, the plans result in highly counterintuitive results given the stated purpose of rationing treatments to the most vulnerable. In New York, for example, a poor, non-Hispanic white person aged 64 with no medical conditions would not be eligible for COVID-19 treatments such as Paxlovid and Molnupiravir, while a healthy, rich, 24-year-old Black person would,³¹ despite people aged 50-64 being 25 times more likely to die from COVID-19 than people aged 18-29.³² And in Minnesota, an 86-year-old non-Hispanic white person with no medical conditions is the equivalent of an 18-year-old Black person with no medical conditions for purposes of receiving COVID-19 treatments,³³ despite an 86-year old being 370 times more likely to die from COVID-19 than an 18 year old.³⁴

III. LEGALITY

Governmental policies that explicitly discriminate based on race must satisfy the strict scrutiny test.³⁵ This test is so demanding that it is often referred to as “strict in theory, fatal in fact.”³⁶ Strict scrutiny applies even when race is only one of many factors considered, as is the case with the Utah and Minnesota policies.³⁷ Strict scrutiny requires the government to demonstrate that the discriminatory action addresses a compelling interest and is narrowly tailored to achieve that

http://www.mssnyenews.org/wp-content/uploads/2021/12/122821_Notification_107774.pdf [<https://perma.cc/PB8R-BEX7>].

31. John Hirschauer, *New York's Anti-White Triage Policy*, AM. CONSERVATIVE (Jan. 12, 2022, 2:15 PM), <https://www.theamericanconservative.com/state-of-the-union/new-yorks-anti-white-triage-policy/> [<https://perma.cc/E5RR-6W9D>] (“[T]he New York Department of Public Health confirmed that age is only considered a qualifying risk factor in New York for individuals aged 65 and older—meaning a white 64-year-old would not, on the basis of his age, be eligible to receive oral antiviral treatment for Covid, while an otherwise-healthy 18-year-old Haitian immigrant would.”).

32. *Risk for COVID-19 Infection, Hospitalization, and Death by Age Group*, CTRS. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html> [<https://perma.cc/S4RJ-EFC3>] (last updated Mar. 9, 2022) [hereinafter *Risk for Covid-19 Infection*].

33. Volokh, *supra* note 17.

34. *Risk for COVID-19 Infection, supra* note 32.

35. *Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989).

36. *See, e.g.*, Gerald Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972). However, some courts have explicitly rebuked this popular saying. *See also, e.g.*, *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 237 (1995) (“Finally, we wish to dispel the notion that strict scrutiny is ‘strict in theory, but fatal in fact.’” (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 519 (1980))).

37. *Fisher v. Univ. of Tex. at Austin*, 570 U.S. 297, 310-11 (2013).

interest.³⁸ Claims as to the altruistic motives of the discrimination are irrelevant in strict scrutiny analysis.³⁹ Likewise, the direction in which the discrimination is applied is also irrelevant.⁴⁰ Meaning, strict scrutiny contains the same exacting rigor regardless of whether it discriminates against or in favor of a disadvantaged class.⁴¹ The policies in question here fail both the compelling governmental interest and the narrowly tailored prongs of the strict scrutiny test.

Governmental policies that discriminate on the basis of race are held to have a compelling interest in remedying past discrimination only when all three of the following criteria are met:

- 1) “[T]he policy must target a specific episode of past discrimination.”⁴²
- 2) “[T]here must be evidence of intentional discrimination in the past Statistical disparities don’t cut it, although they may be used as evidence to establish intentional discrimination.”⁴³
- 3) “[T]he government must have had a hand in the past discrimination it now seeks to remedy.”⁴⁴

The state policies in question here fail all three criteria. The first criterion is not met because the three states do not identify specific incidents of past discrimination.⁴⁵ Rather, they merely “point[] generally to societal discrimination.”⁴⁶ The second element is not met because no evidence of intentional discrimination is provided. “[B]road statistical disparities cited by the government are not nearly enough.”⁴⁷ Finally, the third element is not met because no evidence is presented that the states of Utah, Minnesota, and New York had a hand in the past discrimination they now seek to remedy. The burden would be on the states to prove past discrimination rather than on a plaintiff to prove no past discrimination existed.⁴⁸ And this is a high burden, requiring more than just isolated examples of past discrimination. For example, in a 1993 case involving an affirmative action plan in hiring female firefighters, a finding that

38. *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267, 274 (1986).

39. *Johnson v. California*, 543 U.S. 499, 505 (2005) (“We have insisted on strict scrutiny in every context, even for so-called ‘benign’ racial classifications, such as race-conscious university admissions policies, race-based preferences in government contracts, and race-based districting intended to improve minority representation.” (citations omitted)).

40. *Wygant*, 476 U.S. at 271.

41. *Id.* at 278 (“[T]he level of scrutiny does not change merely because the challenged classification operates against a group that historically has not been subject to governmental discrimination.”).

42. *Vitolo v. Guzman*, 999 F.3d 353, 361 (6th Cir. 2021).

43. *Id.* (citing *Richmond v. J.A. Croson Co.*, 488 U.S. 469, 503 (1989)).

44. *Vitolo*, 999 F.3d at 361.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Brunet v. City of Columbus*, 1 F.3d 390, 405 (6th Cir. 1993).

the city did not intentionally discriminate against women in the past was upheld despite the facts that prior to 1975 women were barred from the position, that only five in 832 firefighters were women, that the director of the training academy was biased against women, and that the city had previously refused to adopt testing methods less discriminatory against women.⁴⁹ As one of the original thirteen colonies, it is no surprise that New York has a history of racist policies, including slavery.⁵⁰ But to meet the strict scrutiny requirement, the past discrimination to be remedied must be direct and recent. Courts have held that governmental policies as recent as fourteen to eighteen years ago were too old to qualify as justification for explicit preferences.⁵¹

At best, these states would be able to demonstrate that prior efforts to eliminate disparate health outcomes in the Black and Hispanic communities were unsuccessful. But such an argument fails because “[a]n observation that prior, race-neutral relief efforts failed to reach minorities is no evidence at all that the government enacted or administered those policies in a discriminatory way.”⁵²

Having established that these policies do not satisfy the compelling interest requirement, they are therefore unconstitutional without any further consideration necessary. However, the policies would also be held unconstitutional under the independent requirement that they be narrowly tailored. This requires that the government show “serious, good faith consideration of workable race-neutral alternatives.”⁵³ A policy that discriminates on the basis of race cannot be upheld unless there is “no workable race-neutral alternative” that would achieve the compelling interest.⁵⁴ Here, not only do race-neutral alternatives exist, but they would be far superior to the racially discriminatory policies. This is because the current policies in question improperly double count race and comorbidities. Being a person of Black race does not, in itself, cause increased risk of death from COVID-19.⁵⁵ Rather, it is the comorbidities, such as obesity and hypertension, that are disproportionately present in the Black community that cause the increased risk.⁵⁶ When factors such as age, sex, socioeconomic status, and

49. *Id.* at 405-06.

50. *History of Slavery in New York*, N.Y. HIST. SOC’Y, <http://www.slaveryinnewyork.org/history.htm> [<https://perma.cc/3HG8-KV8S>] (last visited Jan. 20, 2022).

51. *See, e.g., Brunet*, 1 F.3d at 408-09 (citing examples of racial preferences that were allowed to remedy discrimination that occurred eight years before the preferences were instituted but not after fourteen years had passed); *Hammon v. Barry*, 826 F.2d 73, 76-77 (D.C. Cir. 1987) (holding that a time period of eighteen years between the discriminatory conduct and the institution of the preferences was too remote).

52. *Vitolo*, 999 F.3d at 362.

53. *Grutter v. Bollinger*, 539 U.S. 306, 339 (2003).

54. *Fisher v. Univ. of Tex. at Austin*, 570 U.S. 297, 312 (2013).

55. *See* Baligh R. Yehia et al., *Association of Race with Mortality Among Patients Hospitalized with Coronavirus Disease 2019 (COVID-19) at 92 US Hospitals*, 3 JAMA NETWORK OPEN 1 (Aug. 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769387> [<https://perma.cc/2EPF-FBBG>].

56. *Id.*

comorbidities are controlled for, Hispanic and Black patients with COVID-19 have no greater risk of death than non-Hispanic white patients with COVID-19.⁵⁷ Therefore, by counting both the comorbidity and race as a factor increasing the odds of death, the same factor is essentially being counted twice, resulting in disproportionate significance.

Even setting aside the fatal issue of how the policies are not narrowly tailored because of the double counting issue, the policies are clearly not narrowly tailored because there are numerous race-neutral alternatives available. An incentive program could be implemented to increase vaccination rates, which could help narrow the gap in vaccination between minorities and non-Hispanic whites. If it is determined that the reason Blacks and Hispanics are more likely to have comorbidities is a lack of access to medical care, then race-neutral programs to increase access to health care can be implemented. Likewise, policies to increase access to nutritious foods can be implemented. Innovative methods to deliver free covid tests, such as those implemented by the federal government in January 2022, could be used.⁵⁸ And, perhaps most reasonably, racially neutral means testing that would more accurately distribute COVID-19 treatments to the most vulnerable⁵⁹ could be implemented.

Furthermore, a policy fails the narrowly tailored requirement if it is either overbroad or underinclusive.⁶⁰ “When the government promulgates race-based policies, it must operate with a scalpel.”⁶¹ The three state policies in question are fatally overbroad because they include Asians as minorities to receive preferential treatment in obtaining COVID-19 treatments over non-Hispanic whites.⁶² However, Asian Americans are less likely to test positive for, be hospitalized due to, and die from COVID-19 than non-Hispanic whites.⁶³ This alone is enough to strike down the policies due to not being narrowly tailored.⁶⁴

57. See Rafi Kabarriti et al., *Association of Race and Ethnicity with Comorbidities and Survival Among Patients with COVID-19 at an Urban Medical Center in New York*, 3 JAMA NETWORK OPEN 1 (Sept. 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770960> [<https://perma.cc/6EL4-26T5>] (reporting the findings of a study that found non-Hispanic whites have worse survival rates than both Blacks and Hispanics when relevant factors are controlled for).

58. Mike Winters, *How to Get Free At-Home Covid-19 Test Kits Mailed to Your Door*, CNBC (Jan. 18, 2022), <https://www.cnbc.com/2022/01/18/how-to-get-free-at-home-covid-19-test-kits-mailed-to-your-door.html> [<https://perma.cc/Y28S-SJMD>].

59. See, e.g., *supra* notes 31-34 and accompanying text (demonstrating how a non-Hispanic white person who is 25 times more likely to die from COVID-19 than a Black person is nevertheless deprioritized under the New York system).

60. See *generally* *Richmond v. J.A. Croson Co.*, 488 U.S. 469, 507-08 (1989).

61. *Vitolo v. Guzman*, 999 F.3d 353, 361 (6th Cir. 2021).

62. See Keene, *supra* note 15; see also Seikaly, *supra* note 16; Volokh, *supra* note 17.

63. *Risk for COVID-19 Infection*, *supra* note 32.

64. See *L. Feriozzi Concrete Co. Inc. v. Casino Reinvestment Dev. Auth.*, 776 A.2d 254 (N.J. Super. Ct. App. Div. 2001) (“[T]he plan would still fail since the definitions of minorities are not narrowly tailored to survive a constitutional challenge.”).

The fact that the subject of this racial discrimination is lifesaving medicine in the middle of the deadliest U.S. pandemic in over 100 years also works to diminish any claim that these policies are narrowly tailored. This is because in considering if racial discrimination is narrowly tailored, courts are to consider “the impact of the relief on the rights of third parties.”⁶⁵ Some racial preference policies only result in being denied a promotion, not receiving government funds, or not being accepted into one’s first choice of college. But when the subject is lifesaving COVID-19 treatments, the impact on third parties can include much more significant outcomes such as death.

IV. AFFIRMATIVE ACTION IN COLLEGE ADMISSIONS ANALOGY

Advocates for racial discrimination in COVID-19 treatment are likely to attempt to compare the legally permissible practice of affirmative action in college admissions in an effort to support the legality of their position. Indeed, supporters of racial preferences in vaccine distribution attempted to label the practice “a form of affirmative action of medical resources. . . .”⁶⁶ And there are certainly similarities, such as how both involve a limited resource in which demand far exceeds supply.

Further analysis, however, demonstrates that this attempted comparison fails due to numerous significant differences. The Supreme Court has explained how higher education is a “unique contest” and more of an exception to the generally applicable standards for when racial preferences are allowed.⁶⁷ Affirmative action in higher education is even an outlier in the educational context, as the Supreme Court has struck down racial classifications in high school enrollment.⁶⁸

While COVID-19 treatments and college admissions both have demand that far exceeds supply, they have little else in common. While the benefits of COVID-19 treatments are primarily incurred by the recipient, this is not the case with racial preferences in college admissions. There, the benefit is far more diffuse—to obtain “the educational benefits that flow from student body diversity.”⁶⁹ Therefore, even a student denied admission to an Ivy League college because of his race nevertheless benefits from affirmative action because at whatever “lesser” college he ends up attending, he will benefit from the diverse student body, which is a product of affirmative action. But with COVID-19 treatments, those denied access due to their race do not receive any benefit.⁷⁰ To

65. *United States v. Paradise*, 480 U.S. 149, 171 (1987).

66. Hannah McLane, *A Disturbing Medical Consensus is Growing: Here’s What it Could Mean for Black Patients with Coronavirus*, PUB. BROAD. SERV. (Apr. 10, 2020), <https://why.org/articles/a-disturbing-medical-consensus-is-growing-heres-what-it-could-mean-for-black-patients-with-coronavirus/> [https://perma.cc/8448-H8FK].

67. *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 720 (2007).

68. *Id.*

69. *Fisher v. Univ. of Tex.*, 136 S. Ct. 2198, 2210 (2016).

70. The only exception would be possibly the psychic benefit one gains by knowing that there is an increased probability that the COVID-19 treatment he was denied is more likely to go to a

further illustrate the distinction, there is a stark difference between death from not receiving a lifesaving COVID-19 treatment and not attending one's first choice of college. Attempting to analogize affirmative action in college admissions with racial preferences in COVID-19 treatments is further problematic because the current makeup of the Supreme Court may no longer uphold the existing precedent regarding the former.⁷¹ Chief Justice Roberts's position on affirmative action in college admissions in *Parents Involved in Community Schools v. Seattle School District No. 1*⁷² is illustrative. He stated that "the way to stop discrimination on the basis of race is to stop discriminating on the basis of race."⁷³ One could easily imagine similar rhetoric applied to racial preference in COVID-19 treatments: "The way to stop treating people differently in medicine based on race is to stop treating people differently in medicine based on race."

V. PRAGMATISM

These state policies clearly fail the demanding legal requirements of strict scrutiny. But it is also worthwhile to consider the nonlegal pragmatism behind such a policy. Such consideration illustrates that the unconstitutionality of such a practice is well justified, as it would result in far more harm than good.

- It could result in de facto discrimination in favor of the wealthy. This is because the wealthy are able to finance research into their family histories to locate traces of minority ancestry, thus qualifying as minorities.⁷⁴
- It could result in a lack of trust in future government pronouncements regarding COVID-19. This is because people may view racial discrimination in the administration of lifesaving treatments as blatantly immoral and inefficient, thus calling into question more difficult decisions, such as mask mandates, quarantine timing, and shutdowns. Even worse, this may evoke memories of past instances in which medical

minority. Of course, any such benefit could also be obtained by simply rejecting COVID-19 treatments.

71. Vinay Harpalani, *The Supreme Court and the Future of Affirmative Action*, AM. CONST. SOC'Y (Oct. 28, 2019), <https://www.acslaw.org/expertforum/the-supreme-court-and-the-future-of-affirmative-action/> [<https://perma.cc/LC6X-HCSK>] (explaining that, even before Amy Coney Barrett replaced Ruth Bader Ginsburg, Justices John Roberts, Samuel Alito, Clarence Thomas, Neil Gorsuch, and Brett Kavanaugh would likely vote to strike down affirmative action in college admissions as currently implemented).

72. *Parents Involved in Cmty. Schs.*, 551 U.S. at 701.

73. *Id.* at 748. Significantly, Justices Scalia, Thomas, and Alito joined the part of Chief Justice Roberts's opinion in which this statement was made.

74. Note that with some minority classifications, less than one-half of one percent heredity is required, such as with the Cherokee tribe, which issues Certificate Degree of Indian Blood cards to anyone with at least 1/256 blood quantum. See also *Frequently Asked Questions, How Much Cherokee Am I?*, CHEROKEE NATION, <https://www.cherokee.org/about-the-nation/frequently-asked-questions/miscellaneous/> [<https://perma.cc/7UYL-GD85>] (last visited Jan. 21, 2022).

decisions were made based on race, such as the Tuskegee Syphilis Study, which could result in further diminished trust in the government.

- It could result in normalizing racial discrimination. If the federal government is encouraging it, and state governments are engaging in it, this sends an implicit message that the practice must not be that bad. And the act of engaging in racial discrimination could diminish the moral authority of these states to advocate against and prosecute other forms of racial discrimination.
- Treating Black and Hispanic races as a medical defect that is worse than congestive heart failure⁷⁵ could perpetuate harmful notions of racial inferiority.
- The policy could breed resentment against the groups receiving preferential treatment.⁷⁶ It is easy to see how the family members of a poor, 64-year-old, non-Hispanic white person who died because a lifesaving treatment was instead administered to a rich, 21-year-old, healthy, Black person might allow such an occurrence to result in racial animosity. Furthermore, such instances have proven to be powerful recruitment tools in the hands of white supremacist groups, where they are presented to support notions of martyrdom.⁷⁷
- The policy could even result in negative perceptions of medical racism in the minds of those it seeks to benefit. The percentage of Black people who believe race-based discrimination in health care happens very or somewhat often has been increasing. In 1999 the number was 56%, and in 2020 the number was 70%.⁷⁸
- Asking medical professionals to consider the race of their patients as a basis for treatment decisions is a dangerous precedent. This has been

75. In the Utah policy, being Black or Hispanic is awarded twice as many points as having congestive heart failure. Seikaly, *supra* note 16.

76. This would likely be similar to the link between affirmative action in college admissions and white resentment, except the severity of losing a loved one would likely exacerbate the potential for resentment. *See, e.g.*, Vann R. Newkirk II, *The Myth of Reverse Racism*, ATLANTIC (Aug. 5, 2017), <https://www.theatlantic.com/education/archive/2017/08/myth-of-reverse-racism/535689/> [<https://perma.cc/BG6Y-5UZL>] (discussing “white resentment that’s surrounded the use of race in job and university application processes since the 1960s”).

77. Olga Khazan, *How White Supremacists Use Victimhood to Recruit*, ATLANTIC (Aug. 15, 2017), <https://www.theatlantic.com/science/archive/2017/08/the-worlds-worst-support-group/536850/> [<https://perma.cc/VMS3-Y6FB>]. Similarly, “men’s rights groups” could potentially use this policy to promote notions of male victimhood, since no preferences were given to men despite possessing significantly higher death rates from COVID-19 than women. *See* Ninh T. Nguyen et al., *Male Gender is a Predictor of Higher Mortality in Hospitalized Adults with COVID-19*, 16 PUB. LIBR. SCI. ONE 1 (2021), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0254066> [<https://perma.cc/9GYQ-MHXV>].

78. Liz Hamel et al., *KFF/The Undeclared Survey on Race and Health*, KAISER FAM. FOUND. (Oct. 13, 2020), <https://www.kff.org/report-section/kff-the-undeclared-survey-on-race-and-health-main-findings/> [<https://perma.cc/5BTX-EH49>].

- shown to result in suboptimal health diagnoses from stereotyping.⁷⁹
- Such a policy may even have the unintended consequence of decreasing medical treatment for Black and Hispanic people. This is because the very groups that are targeted—Blacks and Hispanics—could become skeptical as to why they are being prioritized for newly approved and/or experimental treatments. This is similar to how many in the Black community expressed skepticism at the notion of prioritizing Blacks for the COVID-19 vaccine.⁸⁰
 - Such a policy could be viewed as detrimental to racial progress by implicitly promoting the mindset that instead of treating root causes of disparate health outcomes, it is instead preferable to ameliorate the end result. This is exceedingly harmful because focusing on symptoms instead of root causes only perpetuates the status quo and keeps the chain of causation intact.⁸¹
 - Some may incorrectly interpret such a policy as evidence that races are not only different based on aggregate averages but also significantly different at the genetic level. This is a dangerous belief at the root of many white supremacist ideologies.⁸² There is even evidence of the prominence of this false belief among minorities. A 2020 study found that over 25% of Black people believed that their worse health outcomes were the result of genetic differences.⁸³
 - The classification of race is far more subjective than most realize. It is ultimately an “arbitrary biological fiction,”⁸⁴ and even DNA evidence is

79. David E. Bernstein, *Two Decades Ago, the FDA and NIH Mandated the Use of Race to Categorize Subjects and Report Results in Medical and Scientific Research They Oversee. It was a Huge Mistake*, YALE J. ON REG. (July 27, 2020), <https://www.yalejreg.com/nc/two-decades-ago-the-fda-and-nih-mandated-the-use-of-race-to-categorize-subjects-and-report-results-in-medical-and-scientific-research-they-oversee-it-was-a-huge-mistake-by-david-e-bernstein/> [<https://perma.cc/H5HW-N3FJ>].

80. Sigal Samuel, *Should People of Color Get Access to the Covid-19 Vaccine Before Others?*, VOX (Oct. 28, 2020, 10:55 AM), <https://www.vox.com/future-perfect/2020/10/2/21493933/covid-19-vaccine-black-latino-priority-access> [<https://perma.cc/U9J7-CS6D>] (statement of Helene Gayle) (“It’s not hard to imagine that if you put Black and brown people first in the line, there’s going to be some real mistrust about whether or not people are being used as guinea pigs, because in the past they have been . . . [s]o I think it would probably be counterproductive.”).

81. See *Root Cause Analysis Principles*, TONEX, <https://www.tonex.com/root-cause-analysis-principles/> [<https://perma.cc/9FFB-9B52>] (last visited Jan. 21, 2022) (“The logic behind [root cause analysis] is that correcting or completely removing root causes, rather than addressing the surface symptom is the best way to solve the problems.”).

82. See Amy Harmon, *Geneticists Criticize Use of Science by White Nationalists to Justify ‘Racial Purity’*, N.Y. TIMES (Oct. 19, 2018), <https://www.nytimes.com/2018/10/19/us/white-supremacists-science-genetics.html> [<https://perma.cc/6GEN-ALAY>].

83. Hamel et al., *supra* note 78.

84. See Ritchie Witzig, *The Medicalization of Race: Scientific Legitimization of a Flawed Social Construct*, 125 ANNALS INTERNAL MED. 675 (1996).

insufficient to make determinations.⁸⁵ There is no universal standard for race classification; the same person can be classified as a different race depending on which governmental agency is making the determination.⁸⁶ This reality leads some experts to posit that government racial classification judgments “should be dismissed out of hand if for no other reason than the government has no scientific or other reasonable basis for determining who qualifies as African American or Hispanic/Latino.”⁸⁷ The inherent subjectivity of racial classifications, combined with the life-or-death incentive of patients to lie about their racial backgrounds, is likely to be highly problematic. This added step of confirming racial identities could result in delays in treatment, when timing is of utmost importance and hospital staff are in short supply.⁸⁸

- Doctors who view their involvement in administering lifesaving medicine in a racially discriminatory manner as a violation of medical ethics would be put in a difficult position. This unnecessary conflict could result in suspended medical professionals at a time when they are needed the most.
- Finally, the litigation that was inevitably going to follow such a policy—and likely to be successful—is an argument against the pragmatism of implementing such a policy.

VI. CONCLUSION

The racially disparate outcomes from the COVID-19 pandemic shed light on numerous background factors that disadvantage some minority groups. However, the implementation of racial preferences in treatments is not the answer. As demonstrated in this Article, distributing COVID-19 treatment based on racial

85. See Sarah Zhang, *A Man Says His DNA Test Proves He's Black, and He's Suing*, ATLANTIC (Sept. 19, 2018), <https://www.theatlantic.com/science/archive/2018/09/dna-test-race-lawsuit/570250/> [<https://perma.cc/RK3G-GMYF>] (“You cannot rely on DNA evidence alone to decide what is really a socially constructed concept.”).

86. David E. Bernstein, *The Modern American Law of Race*, 94 So. Cal. L. Rev. 171, 173-74 (2021) (providing the example of mixed-race George Zimmerman, who would be classified as different races depending on which entity is doing the classifying and also explaining how the same governmental agency will sometimes change its mind and revoke previously made racial determinations, such as in *Jana-Rock Construction, Inc. v. New York State Department of Economic Development*, 438 F.3d 195 (2d Cir. 2006)).

87. Bernstein, *supra* note 79.

88. As New York City’s Health Commissioner Dr. Dave A. Chokshi explains, “the science shows that monoclonal antibody treatments work and can make all the difference when it comes to the severity of COVID-19 illness [T]reatment should be given as soon as possible after someone tests positive for COVID-19” Press Release, N.Y.C. Health Dep’t, *Monoclonal Antibody Treatments Save Lives, Health Department Reminds New Yorkers* (Oct. 26, 2021), <https://www1.nyc.gov/site/doh/about/press/pr2021/monoclonal-antibody-treatments-save-lives.page> [<https://perma.cc/VNQ4-BC77>].

preferences fails all three of the elements required to satisfy a compelling governmental interest, any one of which would be enough to render the entire policy unconstitutional. It also overwhelmingly fails the narrowly tailored requirement for multiple, independent reasons. Furthermore, nonlegal, pragmatic considerations demonstrate that such a policy does far more harm than good.

Existing case law regarding the narrow application of when racial preferences are permissible and the current makeup of the Supreme Court result in the conclusion that the policies implemented in New York, Utah, and Minnesota are unlikely to stand up to judicial scrutiny. This Article serves a valuable function by providing a better understanding of the legal and pragmatic considerations involved in such medical considerations of race. This is of paramount importance not only for the current COVID-19 crisis but also for future pandemics and the rationing of other limited medical resources, such as organ transplants and intensive care unit beds.