HOW DID THIS MANY DEATHS BECOME NORMAL?

The U.S. is nearing 1 million recorded COVID-19 deaths without the social reckoning that such a tragedy should provoke. Why?

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THE UNITED STATES reported more deaths from COVID-19 last Friday than deaths from Hurricane Katrina, more on any two recent weekdays than deaths during the 9/11 terrorist attacks, more last month than deaths from flu in a bad season, and more in two years than deaths from HIV during the four decades of the AIDS epidemic. At least 953,000 Americans have died from COVID, and the true toll is likely even higher because many deaths went uncounted. COVID is now the third leading cause of death in the U.S., after only heart disease and cancer, which are both catchall terms for many distinct diseases. The sheer scale of the tragedy strains the moral imagination. On May 24, 2020, as the United States passed 100,000 recorded deaths, *The New York Times* filled its front page with the names of the dead, describing their loss as "incalculable." Now the nation hurtles toward a milestone of 1 million. What is 10 times incalculable?

Many countries have been pummeled by the coronavirus, but few have fared as poorly as the U.S. Its death rate surpassed that of any other large, wealthy nation—especially during the recent Omicron surge. The Biden administration placed all its bets on a vaccine-focused strategy, rather than the multilayered protections that many experts called for, even as America lagged behind other wealthy countries in vaccinating (and boosting) its citizens—especially elderly people, who are most vulnerable to the virus. In a study of 29 high-income countries, the U.S. experienced the largest decline in life expectancy in 2020 and, unlike much of Europe, *did not bounce back in 2021*. It was also the only country whose lowered life span was driven mainly

by deaths among people under 60. Dying from COVID robbed each American of about a decade of life on average. As a whole, U.S. life expectancy fell by two years—the largest such decline in almost a century. Neither World War II nor any of the flu pandemics that followed it dented American longevity so badly.

Every American who died of COVID left an average of nine close relatives bereaved. Roughly 9 million people—3 percent of the population—now have a permanent hole in their world that was once filled by a parent, child, sibling, spouse, or grandparent. An estimated 149,000 children have lost a parent or caregiver. Many people were denied the familiar rituals of mourning—bedside goodbyes, in-person funerals. Others are grieving raw and recent losses, their grief trampled amid the stampede toward normal. "I've known multiple people who didn't get to bury their parents or be with their families, and now are expected to go back to the grind of work," says Steven Thrasher, a journalist and the author of *The Viral Underclass*, which looks at the interplay between inequalities and infectious diseases. "We're not giving people the space individually or societally to mourn this huge thing that's happened."

After many of the biggest disasters in American memory, including 9/11 and Hurricane Katrina, "it felt like the world stopped," Lori Peek, a sociologist at the University of Colorado at Boulder who studies disasters, told me. "On some level, we owned our failures, and there were real changes." Crossing 1 million deaths could offer a similar opportunity to take stock, but "900,000 deaths felt like a big threshold to me, and we didn't pause," Peek said. Why is that? Why were so many publications and politicians focused on reopenings in January and February—the fourth- and fifth-deadliest months of the pandemic? Why did the CDC issue new guidelines that allowed most Americans to dispense with indoor masking when at least 1,000 people had been dying of COVID every day for almost six straight months? If the U.S. faced half a year of daily hurricanes that each took 1,000 lives, it is hard to imagine that the nation would decide to, quite literally, throw caution to the wind. Why, then, is COVID different?

MANY ASPECTS of the pandemic work against a social reckoning. The threat—a virus—is invisible, and the damage it inflicts is hidden from public view. With no lapping floodwaters or smoking buildings, the tragedy becomes contestable to a degree that a natural disaster or terrorist attack cannot be. Meanwhile, many of those who witnessed COVID's ruin are in no position to discuss it. Health-care workers are still reeling from

"death on a scale I had never seen before," as an intensive-care nurse told me last year. The bereaved face guilt on top of sadness: "I think about the way it would run through families and tight-knit groups and the huge psychological toll as people think, *Am I the one who brought it in?*" Whitney Robinson, a social epidemiologist at the University of North Carolina at Chapel Hill, told me. And though 3 percent of Americans have lost a close family member to COVID, that means 97 percent have not. The two years that were shaved off of the average life span undid two decades of progress in health, but in 2000, "it didn't feel like we were living under a horrible mortality regime," Andrew Noymer, a demographer at UC Irvine, told me. "It felt normal."

To grapple with the aftermath of a disaster, there must first be an aftermath. But the coronavirus pandemic is *still* ongoing, and "feels so big that we can't put our arms around it anymore," Peek told me. Thinking about it is like staring into the sun, and after two years, it is no wonder people are looking away. As tragedy becomes routine, excess deaths feel less excessive. Levels of suffering that once felt like thunderclaps now resemble a metronome's clicks—the background noise against which everyday life plays. The same inexorable inuring happened a century ago: In 1920, the U.S. was hit by a fourth wave of the great flu pandemic that had begun two years earlier, but even as people died in huge numbers, "virtually no city responded," wrote John M. Barry, a historian of the 1918 flu. "People were weary of influenza, and so were public officials. Newspapers were filled with frightening news about the virus, but no one cared."

Fatalism has also been stoked by failure. Two successive administrations floundered at controlling the virus, and both ultimately shunted the responsibility for doing so onto individuals. Vaccines brought hope, which was dashed as uptake stagnated, other protections were prematurely rolled back, and the Delta variant arrived. During that wave, parts of the South and Midwest experienced "a shocking level of death and transmission that was on par with the worst of that previous winter wave," Robinson said, and even so the policy response was anemic at best. As Martha Lincoln, a medical anthropologist at San Francisco State University, told me in *September 2020*, if salvation never comes, "people are going to harden into a fatalistic sense that we have to accept whatever the risks are to continue with our everyday lives."

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America is accepting not only a *threshold* of death but also a *gradient* of death. Elderly people over the age of 75 are 140 times more likely to die than people in their 20s. Among vaccinated people, those who are immunocompromised account for a disproportionate share of severe illness and death. Unvaccinated people are 53 times more likely to die of COVID than vaccinated and boosted people; they're also more likely to be uninsured, have lower incomes and less education, and face eviction risk and food insecurity. Working-class people were five times more likely to die from COVID than college graduates in 2020, and in California, essential workers continued dying at disproportionately high rates even after vaccines became widely available. Within every social class and educational tier, Black, Hispanic, and Indigenous people died at higher rates than white people. If all adults had died at the same rates as college-educated white people, 71 percent fewer people of color would have perished. People of color also died at younger ages: In its first year, COVID erased 14 years of progress in narrowing the life-expectancy gap between Black and white Americans. Because death fell inequitably, so did grief: Black children were twice as likely to have lost a parent to COVID than white ones, and Indigenous children, five times as likely. Older, sicker, poorer, Blacker or browner, the people killed by COVID were treated as marginally in death as they were in life. Accepting their losses comes easily to "a society that places a hierarchy on the value of human life, which is absolutely what America is built on," Debra Furr-Holden, an epidemiologist at the Michigan State University, told me.

These recent trends oozed from older ones. Well before COVID, nursing homes were understaffed, disabled people were neglected, and low-income people were disconnected from health care. The U.S. also had a chronically underfunded public-health system that struggled to slow the virus's spread; packed and poorly managed "epidemic engines" such as prisons that allowed it to run rampant; an inefficient health-care system that tens of millions of Americans could not easily access and that was inundated by waves of sick patients; and a shredded social safety net that left millions of essential workers with little choice but to risk infection for income. Generations of racist policies widened the mortality gap between Black and white Americans to canyon size: Elizabeth Wrigley-Field, a sociologist at the University of Minnesota, calculated that white mortality during COVID was *still* substantially lower than Black mortality in the *pre-pandemic years*. In that light, the normalizing of

COVID deaths is unsurprising. "When deaths happen to people who are already not valued in a million other ways, it's easier to not value their lives in this additional way," Wrigley-Field told me.

While epidemics flow downward into society's cracks, medical interventions rise upward into its peaks. New cures, vaccines, and diagnostics first go to people with power, wealth, education, and connections, who then move on; this explains why health inequities so stubbornly persist across the decades even as health problems change. AIDS activism, for example, lost steam and resources once richer, white Americans had access to effective antiretroviral drugs, Steven Thrasher told me, leaving poorer Black communities with high rates of infection. "It's always a real danger that things get worse once the people with the most political clout are okay," Thrasher said. Similarly, pundits who got vaccinated against COVID quickly started arguing against overcaution and (inaccurately) predicting the pandemic's imminent end. The government did too, framing the crisis as solely a matter of personal choice, even as it failed to make rapid tests, high-quality masks, antibody cocktails, and vaccines accessible to the poorest groups. The CDC's latest guidelines continue that trend, as my colleague Katherine J. Wu has argued. Globally, the richer north is moving on while the poorer south is still vulnerable and significantly unvaccinated. All of this "shifts the burden to the very groups experiencing mass deaths to protect themselves, while absolving leaders from creating the conditions that would make those groups safe," Courtney Boen, a sociologist at the University of Pennsylvania, told me. "It's a lot easier to say that we have to learn to live with COVID if you're not personally experiencing the ongoing loss of your family members."

Richard Keller, a medical historian at the University of Wisconsin at Madison, says that much of the current pandemic rhetoric—the premature talk of endemicity; the focus on comorbidities; the *from*-COVID-or-*with*-COVID debate—treats COVID deaths as dismissible and "so inevitable as to not merit precaution," he has written. "Like gun violence, overdose, extreme heat death, heart disease, and smoking, [COVID] becomes increasingly associated with behavioral choice and individual responsibility, and therefore increasingly invisible." We don't honor deaths that we ascribe to individual failings, which could explain, Keller argues, why national moments of mourning have been scarce. There have been few pandemic memorials, save some moving but

temporary art projects. Resolutions to turn the first Monday of March into a COVID-19 Victims and Survivors Memorial Day have stalled in the House and Senate. Instead, the U.S. is engaged in what Keller calls "an active process of forgetting." If safety is now a matter of personal responsibility, then so is remembrance.

NO ONE KNOWS how many people will die from COVID in the coming years. The number will depend on our collective behavior, how many more people can be vaccinated or boosted, the length and strength of immunity, what new variants arise, and more. Andrew Noymer, the demographer, thinks that COVID will kill fewer people per year than it has in the past two, but will probably still be more lethal than the flu, which sets a plausible and very wide range of somewhere between 50,000 and 500,000 annual deaths. (COVID will also continue to cause long-term disability.)

How much of this extra mortality will the U.S. accept? The CDC's new guidelines provide a clue. They recommend that protective measures such as indoor masking kick in once communities pass certain thresholds of cases and hospitalizations. But the health-policy experts Joshua Salomon and Alyssa Bilinski calculated that by the time communities hit the CDC's thresholds, they'd be on the path to at least three daily deaths per million, which equates to 1,000 deaths per day nationally. And crucially, the warning lights would go off too late to prevent those deaths. "As a level of mortality the White House and CDC are willing to accept before calling for more public health protection, this is heartbreaking," Salomon said on Twitter.

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If 1,000 deaths a day is not acceptable, what threshold would be? The extreme answer —*none!*—is impractical, because COVID has long passed the point where eradication is possible, and because all interventions carry at least some cost. Some have suggested that we should look to other causes of death—say, 39,000 car fatalities a year, or between 12,000 and 52,000 flu deaths—as a baseline of what society is prepared to tolerate. But this argument rests on the false assumption that our acceptance of those deaths is informed. Most of us simply don't know how many people die of various causes—or that *it's possible for fewer to do so*. The measures that protected people from

COVID slashed adult deaths from flu and all but eliminated them among children. Our acceptance of those deaths never accounted for alternatives. "When was I offered the choice between having a society where you're expected to go into work when you're ill or having fewer people die of the flu every year?" Wrigley-Field, the sociologist, said to me.

Even when the potential benefits are clear, there's no universal algorithm that balances the societal disruption of a policy against the number of lives saved. Instead, our attitudes about preventing death revolve around how possible it seems and how much we care. About 40,000 Americans are killed by guns every year, but instead of preventing these deaths, "we have organized ourselves around the inevitability of gun violence," Sonali Rajan of Columbia University's Teachers College said on Twitter.

Doing the same for COVID, as Rajan says is now happening, means prematurely capitulating to the pathogens that come next. The inequities that were overlooked in this pandemic will ignite the next one—but they don't have to. Improving ventilation in workplaces, schools, and other public buildings would prevent deaths from COVID and other airborne viruses, including flu. Paid sick leave would allow workers to protect their colleagues without risking their livelihood. Equitable access to antivirals and other treatments could help immunocompromised people who can't be protected through vaccination. Universal health care would help the poorest people, who still bear the greatest risk of infection. A universe of options lies between the caricatured extremes of lockdowns and inaction, and will save lives when new variants or viruses inevitably arise.

Such changes are popular. Stephan Lewandowsky, from the University of Bristol, presented a representative sample of Americans with two possible post-COVID futures —a "back to normal" option that emphasized economic recovery, and a "build back better" option that sought to reduce inequalities. He found that most people preferred the more progressive future—but wrongly assumed that most other people preferred a return to normal. As such, they also deemed *that* future more likely. This phenomenon, where people think widespread views are minority ones and vice versa, is called pluralistic ignorance. It often occurs because of active distortion by politicians and the press, Lewandowsky told me. (For example, a poll that found that mask mandates are favored by 50 percent of Americans and opposed by just 28 percent was

nonetheless framed in terms of waning support.) "This is problematic because over time, people tend to adjust their opinions in the direction of what they perceive as the majority," Lewandowsky told me. By wrongly assuming that everyone else wants to return to the previous status quo, we foreclose the possibility of creating something better.

There is still time. Steven Thrasher, the journalist, noted that a new wave of AIDS memorials is only now starting to show up, long after the start of that pandemic. COVID will similarly persist, as will the chance to reckon with its cost, and the opportunity to steel our society against similar threats. Right now, the U.S. is barreling toward the next pandemic, having failed to learn the lessons of the past two years, let alone the past century. But Wrigley-Field, the sociologist, told me that she draws inspiration from the big social movements of the past, where gains in equality that seemed impossible at first were eventually achieved. "We're really bad judges of what is possible based on what we're experiencing in a particular moment," she said. "Nothing major that has mattered for health came quickly or easily."

This article originally reported a higher-end estimate of 17 years of life, on average, lost to COVID. The correct estimate is closer to a decade.