Holistic Lessons from a pandemic:

'All Lives Can't Truly Matter Until Black Lives Matter'

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The COVID-19 pandemic while characterised by global upheaval, widespread loss and an unprecedented use of the word 'unprecedented'[1], has also been an unparalleled time of reflection. This collective social awakening has illuminated the inequalities, injustices, and institutionalised racism that have underpinned our societal structures for centuries. Originally thought to be the 'great equaliser'[2], COVID-19 has instead cataclysmically exploited existing socioeconomic and health disparities, conferring a disproportionate impact in UK's Black, Asian and Minority Ethnic (BAME) communities[3]. Within this, mortality and morbidity is by far the highest in the Black Caribbean and African ethnic groups[4]. This commentary aims to elucidate the determinants of these inequities whilst proposing systemic solutions to alleviate racism as a health risk. In essence, true holism cannot hope to be achieved until we value the intrinsic life and role of every Black, Asian and Minority Ethnic individual to the fullest extent[5].

A point to note going forwards are the contextual limitations of the terms 'BAME' or 'Ethnic Minority' used in this review and widely through UK race-equality literature[6]. Originally intended to diversify marginalised minority representation, these umbrella terms are ultimately reductionist. They conflate and dilute the experiences and oppressions of heterogenous groups or more insidiously, are used to massage 'diversity quotas', particularly in regards to disadvantaging UK's black communities. Unfortunately, data collection by specific ethnic group is still limited and often subject to small sample sizes[7]. So while realising the importance of language in culture to foster respect, this paper attempts to report this available data as directly as possible. I write ahead with humility, transparency and willingness to continually educate myself to engage in a conversation that persistently needs to be had (until the day where nebulous labels are no longer needed because discrimination does not exist – let us hope this is within our lifetimes).

COVID-19 AND ETHNIC MINORITY GROUPS

The literature now widely agrees that Black, Asian and Minority Ethnic individuals are at an increased risk of acquiring and dying from the SARS-CoV-2 infection compared to White individuals[8]. Early data showed that 34% of people admitted to intensive care for COVID-19 were from BAME communities, despite only making up 14% of the wider population[9]. Here Black women and men were 4.3 and 4.2 times more likely to die than their White counterparts. Bangladeshi and Pakistani men had the second highest mortality rate(1.8 times > White men)[10]. These strikingly disproportionate effects were demonstrated even after adjusting for geographical region, age, self-reported disability, and socio-demographics[11,12].

Similar consequences have been seen in our BAME healthcare colleagues. An overwhelming 90% of doctors, 64% of nurses and 63% of healthcare workers who lost their lives after contracting coronavirus on the frontlines belonged to Ethnic Minority communities[13].

While collating up-to-date figures is of utmost public health importance, it is vital these lives are remembered as more than just statistics. They are somebody's parents, grandparents and children. Moreover, they are somebody. They are *essential*, not expendable people to whom the NHS has pledged a duty of care. Implementing protective measures for these communities is therefore paramount, as is investigating why these disparities exist.

DETERMINANTS OF RACIAL HEALTH INEQUALITIES

Examining the determinants of these observations illustrates a complex interplay between several factors. These include; inability to comply with social distancing recommendations due to domicile overcrowding, occupation or public transport needs; underlying health disparities in access to nutrition or outdoor spaces; limited accessibility to preventive services or information arising from linguistic barriers; and intersecting stigmas/implicit racial bias affecting healthcare delivery[2,10,14,15]. These structurally pervasive factors may influence a combination of disease exposure, transmission and/or prognosis[11]. They also make it difficult to follow the government's *'stay-at-home-but-go-to-work-but-also-stay-alert'* coronavirus strategy[16].

Explaining the disproportionate effect on socioeconomically secure healthcare professionals requires further exploration. A BMA survey showed over a 1/3rd of UK BAME doctors were not being given COVID-19 risk-assessments, were more frequently deployed to frontline roles involving extensive exposure to high viral loads[17,18] and twice as likely to feel pressured into treating patients without adequate PPE than White colleagues[17]. Arguably this reflects broader issues of Minority Ethnic groups being over-represented at lower levels of the NHS-grade hierarchy and systemic racial barriers to career progression. These impede the ascension of marginalised groups to leadership and senior-management roles[18]. It may also be explained by a hesitancy to raise concerns as a by-product of feeling like an outsider, experiences of harassment or fear of unjust reprisal[12].

Several biological explanations for the effect of COVID-19 on BAME groups have also been touted and at first glance they are seemingly sensible premises[19]. Individuals from African backgrounds are prone to higher blood pressures[20] while South Asians are more likely to develop cardiovascular disease[21]. Both are also more likely to have type 2 diabetes than the wider population[22]. These underlying/co-morbid health conditions could exacerbate COVID-19 outcomes. Further studies, investigating possible genetic polymorphisms[23–25], ethnic differences in lung function[26–28] and vitamin D deficiencies[29–31] are still inconclusive[32], and do little to relay the complete picture.

The limitations of inquiries based solely on biological determinism should therefore be highlighted. Firstly, these biological risks are offset significantly by *protective* factors; Asian and Black ethnic groups are less likely to smoke[33] or drink hazardously[34] and South Asians have lower rates of cancer than White groups[35]. Moreover, 'race' in essence is itself a *social* construct. It has historically been wielded against Black communities to naturalise inferiority and difference, and is rooted in colonialist legacies of oppression[36]. Thus a truly holistic explanation endeavours to understand exactly how upstream socioeconomic determinants of health inequality interact with and mould seemingly *independent* downstream biological factors[37]. An example of this would be how living in deprived/underfunded areas with more air-pollution can exacerbate underlying respiratory illnesses[38]. It is therefore imperative to examine how perceptions of 'race' impact health and ultimately how Racism itself is a health risk.

RACISM IS A HEALTH RISK

Racism is widely misunderstood to consist solely of prejudiced interpersonal encounters, which themselves contribute to worsening mental health[7]. In reality, hierarchical ideologies of racial inferiority shape socio-demographics, socio-economics and health cyclically across generations. Police brutality against black communities[39] may be the apex of a pyramid of oppression, but is propped up by insidious structural racism embedded in laws, policies and practices of almost every organisation including, regrettably the NHS[40,41], healthcare/humanitarian-aid organisations[42] and medical education[43]. Here racial stereotyping, implicit-bias, and a lack of cultural competance have life-threatening repercussions. Studies show Black women are five times as likely to die from preventable complications during pregnancy/childbirth than White women[44,45]. Equally, misguided attitudes about pain-perception or the pressures on black women to be stereotypically 'strong' and 'independent', have led Black people to be routinely undertreated for pain[46,47]. Remedial action must be taken to redesign the systems that prejudicially perpetuate this suffering.

SYSTEMIC SOLUTIONS

As we rebuild the world in the wake of a global crisis, we have an invaluable opportunity to transform it into a fairer, more compassionate version of itself. First we must listen and amplify the voices of grassroot race-equality organisations, communities with lived experience and Black clinical professionals (many of whom are cited in this piece). This is imperative for tailored implementation of *immediate* measures e.g. risk assessments/PPE for ethnic minority workers, income security safety nets, and dissemination of culturally sensitive health messaging[11].

Moreover, these voices should be given tools to guide *long-term* changes in institutions of medical education and healthcare. This requires the ethnic demographics of healthcare leaders in policy and research to be proportionately representative of the communities they serve and study[48]. While doctors are undeniably skilled at empathetically putting themselves in a range of patient shoes, training cannot always

replace the trust garnered by a doctor belonging to the same culture. A nuanced understanding of a patient's culture can positively influence motivational interviewing – improving a patient's experience of illness and adherence to medical advice. Equally, studying at an ethnically diverse medical school increases the collective cultural competency and attainment of the entire cohort, strengthening the rationale for Widening Access programmes, already running in several universities, mine included.

Beyond promoting 'diversity and inclusion', holistic discussions about the race attainment gap[49] must sit on the axis of decolonialisation[50]. This means medical universities have a duty to weave anti-racism into their praxis, committing to meaningful, empowering support for its existing and future Black students. In line with this are initiatives to make the medical curriculum more racially aware[51]. This includes teaching with ethnically diverse case examples, especially when disease presentation differs between people of different skin tones[52]. For example, the diagnostic rashes in Kawasaki disease/Meningococcaemia can be significantly less visible in children with darker skin tones, as are clinical signs like 'cyanosis' and 'pallor'[52]. Moreover, learning about implicit-bias and how racism influences socioeconomic determinants of health is vital for students, many of whom will proceed to shape public health policies.

CONCLUSION

If we wish for the NHS to live up to its founding principles of fairness, equality and compassion for all, we must urgently take action to address all facets of racial discrimination; in healthcare, institutions of medical education and most importantly, within ourselves.

BILBIOGRAPHY

1. Authers J. Coronavirus: “Unprecedented” Overuse Fuels False Market Hopes - Bloomberg. Bloomberg Opinion. https://www.bloomberg.com/opinion/articles/2020-05-07/coronavirus-unprecedented-overuse-fuels-false-market-hopes. Published 2020. Accessed July 10, 2020.
2. Okonkwo NE, Aguwa UT, Jang M, et al. COVID-19 and the US response: accelerating health inequities. *BMJ Evidence-Based Med*. June 2020:bmjebm-2020-111426. doi:10.1136/bmjebm-2020-111426
3. Public Health England. *Beyond the Data : Understanding the Impact of COVID-19 on BAME Groups*.; 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf.
4. Platt L, Warwick R. *Are Some Ethnic Groups More Vulnerable to COVID-19 than Others?*; 2020. www.nuffieldfoundation.org. Accessed July 9, 2020.
5. Jones C. How Racism Makes People Sick: A Conversation with Camara Phyllis Jones, MD, MPH, PhD | Kaiser Permanente Institute for Health Policy. Kaiser Permanente Institute for Health Policy. https://www.kpihp.org/blog/how-racism-makes-people-sick-a-conversation-with-camara-phyllis-jones-md-mph-phd/. Published 2016. Accessed July 9, 2020.
6. Navjoyt Ladher. Let’s talk about race - The BMJ. *BMJ Opin*. 2020. https://blogs.bmj.com/bmj/2020/02/13/navjoyt-ladher-lets-talk-about-race/. Accessed July 8, 2020.
7. Mental Health Foundation. BAME and mental health. https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities. Published 2019. Accessed July 4, 2020.
8. Pan D, Sze S, Minhas JS, et al. The impact of ethnicity on clinical outcomes in COVID-19: A systematic review. *EClinicalMedicine*. 2020;23:100404. doi:10.1016/j.eclinm.2020.100404
9. Intensive Care National Audit & Research Centre. ICNARC report on COVID-19 in critical care - 04 April 2020. 2020;(April):1-16.
10. ONS. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales. *Off Natl Stat*. 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020. Accessed July 9, 2020.
11. Aldridge RW, Lewer D, Katikireddi SV, et al. Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data. *Wellcome Open Res*. 2020;5:88. doi:10.12688/wellcomeopenres.15922.1
12. Royal College of Psychiatrists. Impact of COVID-19 on Black , Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk. 2020;2020(May).
13. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19. Health Service Journal. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article. Published 2020. Accessed July 4, 2020.
14. Abdul Razaq, Dominic Harrison, Sakthi Karunanithi, et al. BAME COVID-19 DEATHS - What do we know? Rapid Data & Evidence Review. *Cent Evidence-Based Med*. 2020. https://www.cebm.net/covid-19/bame-covid-19-deaths-what-do-we-know-rapid-data-evidence-review/. Accessed July 9, 2020.
15. Mamluk, Loubaba, Jones, Tim. *The Impact of COVID-19 on Black, Asian and Minority Ethnic Communities*.; 2020.
16. The Economist. Alert, but confused - Boris Johnson’s new covid-19 campaign falls flat. The Economist. https://www.economist.com/britain/2020/05/10/boris-johnsons-new-covid-19-campaign-falls-flat. Published 2020. Accessed July 10, 2020.
17. BMA. BAME doctors being placed at risk due to lack of Covid-19 risk assessments, BMA survey reveals. British Medical Association. https://www.bma.org.uk/bma-media-centre/bame-doctors-being-placed-at-risk-due-to-lack-of-covid-19-risk-assessments-bma-survey-reveals. Published 2020. Accessed July 5, 2020.
18. ITV. ‘Discrimination’ on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff - ITV News. *ITV news*. https://www.itv.com/news/2020-05-

13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism/. Published 2020. Accessed July 4, 2020.
19. Abuelgasim E, Saw LJ, Shirke M, Zeinah M, Harky A. COVID-19: Unique public health issues facing Black, Asian and minority ethnic communities. *Curr Probl Cardiol*. 2020;45(8). doi:10.1016/j.cpcardiol.2020.100621
20. Khan JM, Beevers DG. Management of hypertension in ethnic minorities. *Heart*. 2005;91(8):1105-1109. doi:10.1136/hrt.2004.044560
21. Schiffrin EL, Flack JM, Ito S, Muntner P, Webb RC. Hypertension and COVID-19. *Am J Hypertens*. 2020;33(5). https://gisanddata.maps.arcgis. Accessed July 10, 2020.
22. Brogan S, Matthews G. Who said pandemics don't discriminate. https://www.leighday.co.uk/Blog/June-2020/Who-said-pandemics-don't-discriminate?utm_campaign=coschedule&utm_source=twitter&utm_medium=LeighDay_Law. Published 2020. Accessed July 5, 2020.
23. Wu Y-H, Tseng C-P, Cheng M-L, Ho H-Y, Shih S-R, Chiu DT-Y. Glucose-6-Phosphate Dehydrogenase Deficiency Enhances Human Coronavirus 229E Infection. *J Infect Dis*. 2008;197(6):812-816. doi:10.1086/528377
24. Chiu RWK, Tang NLS, Hui DSC, et al. ACE2 Gene Polymorphisms Do Not Affect Outcome of Severe Acute Respiratory Syndrome. *Clin Chem*. 2004;50(9):1683-1686. doi:10.1373/clinchem.2004.035436
25. Khashkhusha TR, Chan JSK, Harky A. ACE inhibitors and COVID-19: We don't know yet. *J Card Surg*. 2020;35(6):1172-1173. doi:10.1111/jocs.14582
26. Braun L, Wolfgang M, Dickersin K. Defining race/ethnicity and explaining difference in research studies on lung function. *Eur Respir J*. 2013;41(6):1362-1370. doi:10.1183/09031936.00091612
27. Saad NJ, Patel J, Minelli C, Burney PGJ. Explaining ethnic disparities in lung function among young adults: A pilot investigation. Larcombe A, ed. *PLoS One*. 2017;12(6):e0178962. doi:10.1371/journal.pone.0178962
28. Korotzer B, Ong S, Hansen JE. Ethnic differences in pulmonary function in healthy nonsmoking Asian-Americans and European-Americans. *Am J Respir Crit Care Med*. 2000;161(4 I):1101-1108. doi:10.1164/ajrccm.161.4.9902063
29. Grant WB, Lahore H, McDonnell SL, et al. Evidence that Vitamin D Supplementation Could Reduce Risk of Influenza and COVID-19 Infections and Deaths. *Nutrients*. 2020;12(4):988. doi:10.3390/nu12040988
30. Martineau AR, Jolliffe DA, Greenberg L, et al. Vitamin D supplementation to prevent acute respiratory infections: individual participant data meta-analysis. *Health Technol Assess (Rockv)*. 2019;23(2):1-44. doi:10.3310/hta23020
31. Patel J V., Chackathayil J, Hughes EA, Webster C, Lip GYH, Gill PS. Vitamin D deficiency amongst minority ethnic groups in the UK: A cross sectional study. *Int J Cardiol*. 2013;167(5):2172-2176. doi:10.1016/j.ijcard.2012.05.081
32. Raisi-Estabragh Z, McCracken C, Bethell MS, et al. Greater risk of severe COVID-19 in non-White ethnicities is not explained by cardiometabolic, socioeconomic, or behavioural factors, or by 25(OH)-vitamin D status: study of 1,326 cases from the UK Biobank. *medRxiv*. 2020:2020.06.01.20118943. doi:10.1101/2020.06.01.20118943
33. gov.uk. Cigarette smoking among adults: Ethnicity facts and figures. gov.uk. https://www.ethnicity-facts-figures.service.gov.uk/health/alcohol-smoking-and-drug-use/adult-smokers/latest#by-ethnicity. Published 2019. Accessed July 10, 2020.
34. gov.uk. *Harmful and Probable Dependent Drinking in Adults - Ethnicity Facts and Figures*.; 2018. https://www.ethnicity-facts-figures.service.gov.uk/health/alcohol-smoking-and-drug-use/harmful-and-probable-dependent-drinking-in-adults/latest#by-ethnicity-and-sex-low-risk-drinking. Accessed July 10, 2020.
35. Public Health England. National Cancer Intelligence Network Cancer and equality groups : key metrics 2014 report About Public Health England. 2014.
36. Lokugamage AU, Fyfe M. Structural racism in society and the covid-19 "stress test" - The BMJ. The BMJ Opinion. https://blogs.bmj.com/bmj/2020/06/08/structural-racism-in-society-and-the-covid-

19-stress-test/. Published 2020. Accessed July 5, 2020.
37. Elwell-Sutton T, Deeny S, Stafford M. Emerging findings on the impact of COVID-19 on black and minority ethnic people | The Health Foundation. The Health Foundation. https://www.health.org.uk/news-and-comment/charts-and-infographics/emerging-findings-on-the-impact-of-covid-19-on-black-and-min. Published 2020. Accessed July 10, 2020.
38. de Preux L, Sassi F. Health Impacts of All Pollution – what do we know? *Annu Rep Chief Med Off*. 2017:187. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/690846/CMO_Annual_Report_2017_Health_Impacts_of_All_Pollution_what_do_we_know.pdf.
39. Alang S, McAlpine D, McCreedy E, Hardeman R. Police brutality and black health: Setting the agenda for public health scholars. *Am J Public Health*. 2017;107(5):662-665. doi:10.2105/AJPH.2017.303691
40. Kar P. Partha Kar: To tackle racism, the NHS needs policies with teeth. *BMJ*. 2020;369:m2583. doi:10.1136/bmj.m2583
41. Brathwaite B. Black, Asian and minority ethnic female nurses: Colonialism, power and racism. *Br J Nurs*. 2018;27(5):254-258. doi:10.12968/bjon.2018.27.5.254
42. Abdelmoneim J. Addressing racism in MSF. Médecins Sans Frontières UK. https://www.msf.org.uk/article/addressing-racism-msf. Published 2020. Accessed July 10, 2020.
43. Romano MJ. White privilege in a white coat: How racism shaped my medical education. *Ann Fam Med*. 2018;16(3):261-263. doi:10.1370/afm.2231
44. Iacobucci G. Birthing care without racism: five minutes with . . . Kimberly Seals Allers. *BMJ*. 2020;368:m424. doi:10.1136/bmj.m424
45. Anekwe L. Ethnic disparities in maternal care. *BMJ*. 2020;368. doi:10.1136/bmj.m442
46. Bignall T, Jeraj S, Helsby E, Butt J. Racial disparities in mental health: literature and evidence review. *Race Equal Found Heal Well-being Alliance*. 2019:60.
47. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296-4301. doi:10.1073/pnas.1516047113
48. Adebowale V, Rao M. Racism in medicine: why equality matters to everyone. *BMJ*. 2020;368. doi:10.1136/bmj.m530
49. Claridge H, Stone K, Ussher M. The ethnicity attainment gap among medical and biomedical science students: A qualitative study. *BMC Med Educ*. 2018;18(1). doi:10.1186/s12909-018-1426-5
50. Ali M, Dhlamini B. WORLD: we got this | Episode 5 (Part 2) | Racism is a health risk. WORLD: we got this Podcast by King's College London. https://soundcloud.com/worldwegotthis/racism-is-a-health-risk-part-2. Published 2020. Accessed July 4, 2020.
51. Gishen F, Lokugamage A. Diversifying and Decolonising the Medical Curriculum. *BMJ*. 2018;Oct 18. https://blogs.bmj.com/bmj/2018/10/18/diversifying-and-decolonising-the-medical-curriculum/. Accessed July 11, 2020.
52. Agu C. Petition: Medical schools must include BAME representation in clinical teaching. Change.org. https://www.change.org/p/gmc-medical-schools-must-include-bame-representation-in-clinical-teaching. Published 2020. Accessed July 11, 2020.