To be, or not to be BAME, in the time of COVID-19: does it matter?

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"...whether 'tis nobler in the mind to suffer the slings of outrageous fortune, or take arms against a sea of troubles and by opposing, end them” Hamlet, William Shakespeare

Coronavirus disease (COVID-19) is currently on a rampant second wave across the globe. The United Kingdom (UK) has the highest death rate in Europe.1 The UK also has the most diverse population in Europe: 14% of the UK population are from black, Asian and minority ethnic (BAME) groups known to have greater consequences of the COVID-19 infection and subsequent worse mortality.2

In an observational UK study comparing linked acute coronary syndrome data during the COVID-19 infection lockdown (February to May 2020) with the same time period in the preceding 3 years (2017–2019), Rashid and colleagues report troublesome findings. Specifically, higher in-hospital and 7-day mortality rates for acute myocardial infarction in BAME populations during the COVID-19 pandemic than in white populations.3 These disproportionate rates reflect alarming patterns of healthcare delivery to, and outcomes observed in, minority ethnic populations across the globe, and mirror the well-described disparities seen in multiethnic populations of the United States (USA).4 But do these differences qualify as race-based health inequities? Is the UK health service now complicit in the provision of disparate care?

In their paper, Rashid et al report that BAME patients during COVID-19 lockdown were more likely to present with ST segment elevation myocardial infarction, out of hospital cardiac arrest and cardiogenic shock.3 These important differences in disease acuity might easily account for poorer outcomes and would direct focus towards healthcare-seeking behaviours, rather than disparate care, as targets of intervention. However, delays in the management of acute coronary syndrome presentations, a reduction in invasive angiography in non-ST segment elevation myocardial infarction and less likelihood of undergoing percutaneous revascularisation are issues that should be unwavering, regardless of the patient demographic. Moreover, BAME patients were less likely to receive guideline-mandated care—for example, dual antiplatelet therapy. It is sobering to note that such delays in angiography and reperfusion therapies, although more pronounced during the COVID-19 periods, were also prevalent during the pre-COVID-19 periods.3 These observations now fully qualify as evident healthcare inequalities and reinforce disconcerting disparities in cardiovascular care affecting BAME populations. In the USA, COVID-19 is the bellwether event exposing gaps in care for minorities in comparison with all others. Now in the UK, our complicity with the provision of disparate care is exposed.

A biological premise to explain the observed differences does not exist. There is no genetic component specific to any ethnic group sufficient to explain the increased adverse outcomes seen among BAME populations across the UK (and in the USA).3

We must instead focus on two major areas: patient-based factors (sociodemographics, psychosocial issues in seeking healthcare, delayed presentations, concomitant comorbidities) otherwise known as the social determinants of health; and physician-based factors potentially arising from implicit or subconscious bias and leading to unfavourable decision-making.

PUBLIC POLICY AND BAME SUSCEPTIBILITY TO POOR OUTCOMES

Common to both the US and the UK are the large numbers of ethnic minorities living in socially disadvantaged and densely populated neighbourhoods, in households reporting lower income, and in poor housing conditions that preclude proper social distancing.2 4-6 In the USA, these neighbourhood level factors are known to reflect recalcitrant discrimination and structural inequalities in society, attributed to longstanding social policies, which have resulted in limited access to high-quality education and fewer life opportunities for black US residents than for white people.4 5 This, in turn, leads to a higher incidence of unemployment or lower-paying jobs; ethnic minorities both in the USA and the UK are disproportionately represented in essential work settings, such as farms, factories, healthcare, grocery stores and public transportation, making them more ‘virus facing’.2 4-6 Limited educational opportunities also lead to lower access to health-promoting environments, unhealthy dietary habits, poorer health literacy and healthcare awareness.6 Such ethnic inequalities may be associated with decreased symptom recognition and poor engagement with health services, resulting in a reduced tendency to health-seeking behaviour, which may be further impeded by language barriers.2 4 As Shakespeare wrote, this is a ‘sea of troubles’.

Unlike the USA, the UK, via the National Health Service, has universal healthcare—a resource that many expected would reduce or even eliminate health inequalities. The fact that disparities in healthcare delivery and outcomes still exist in the UK, underscores the need for deeper reflection and an intentional search for both patient- and physician-based factors leading to such disparities, together with identification of actionable mitigation measures (table 1).

Is there a path forward? We need to deal with barriers to equitable health, including structural racism and social factors—that is, education, housing and poverty. We need to invest in early child health, reducing childhood poverty and illnesses, improving access to education, and increasing opportunities for higher-quality employment. By doing so, this will reduce the welfare demands on the state from underprivileged populations and redirect those resources towards services that will eliminate these untenable ethnicity-based health outcomes. Our national policy is the contract with the population; we have a moral imperative to invest in housing, healthier neighbourhoods and safe spaces for exercise. Dealing with these sociodemographic factors calls for collective efforts on the part of governments, states, policy makers, industry, physicians and community leaders.

PHYSICIANS AND BAME POPULATIONS

While these longer-term solutions requiring the involvement of policy-makers and while stakeholders are churning through the requisite bureaucracies, physicians and
We cannot be cowards: we must learn to see the world from another’s eyes and not place our prejudice on our patients. We must learn to identify and then remove the impact of bias on our patient outcomes. We should champion diversity and inclusion within our professions, so that more of our patients have physicians that look like them, identify with their cultures and can tailor treatment appropriately. We must be empowered to draw attention to biased behaviour when we see it and be an advocate for all our patients.

Sadly, in the time of COVID-19 particularly, but in all other times more generally, to be BAME matters greatly and puts our UK BAME populations at risk. While we concentrate efforts towards mitigating the adverse impacts of the current pandemic, deploying vaccines and discovering new therapies, we must “take up arms against this sea of troubles, and by opposing, end them.”

Correction notice Since Online First publication, a typographical error in the table has been corrected.

Table 1 Problems and proposed interventions to address ethnic differences in healthcare delivery and outcomes

<table>
<thead>
<tr>
<th>Timing</th>
<th>The problem</th>
<th>The intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td>Physician implicit bias</td>
<td>Training: school, medical school and through working lives</td>
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<tr>
<td></td>
<td>Inadequate health awareness from BAME communities</td>
<td>Linguistically and culturally appropriate, community-targeted public health messaging</td>
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<tr>
<td>Medium term</td>
<td>Physician implicit bias</td>
<td>Training: school, medical school and through working lives</td>
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<tr>
<td></td>
<td>Patient behaviours</td>
<td>Training and education via places of worship and community organisations in languages they understand</td>
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<td></td>
<td>Poor representation of ethnic minorities in research</td>
<td>Development of research and clinical trials that reflect racial, ethnic and socioeconomic diversity.</td>
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<tr>
<td>Long term</td>
<td>Address socioeconomic determinants of health</td>
<td>Investment in communities</td>
</tr>
<tr>
<td></td>
<td>Lack of trust and understanding in healthcare providers</td>
<td>Foster pipeline of physicians reflective of the ethnicities they treat</td>
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BAME, black, Asian and ethnic minority.

care providers must exercise an ‘accountability moment’. As an element of ground truth, we all function with implicit biases. The question is whether we ‘take arms’ against the pernicious outcomes of biased decision-making.

In the past year, public health experts nationwide have acknowledged the role ‘medical racism’ plays in healthcare, declaring racism a public health threat.7 This socially aware commentary is just, but tragedies persist. The tragic case of Dr Susan Moore: a 52-year-old African-American physician from Indianapolis, USA, with COVID-19 infection, disturbingly proves our conventional management of BAME patients and exposes our likely implicit biases. Providers ignored, downplayed and dismissed her symptoms; she archived on video her plaintive plea to her fellow physicians to help save her. “I put forth and maintain, if I was white, I wouldn’t have to go through that,” she says in a 4 December video on Facebook.8 “This is how black people get killed, when you send them home, and they don’t know how to fight for themselves”. In the case of her tragic death on 20 December, the majority of patient factors outlined above, the sea of troubles, did not apply—only discrimination.8 Is this an accountability moment for us as well? How hard is this to read? How similar is this to the care for acute coronary syndrome experienced by BAME populations in the UK?

“Thus conscience does make cowards of us all, and thus the native hue of resolution is sicklied o’er with the pale case of thought”

### REFERENCES


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