

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).⁵

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 5 6} Limited educational opportunities also lead to lower access to health-promoting environments, unhealthy dietary habits, poorer health literacy and healthcare awareness.^{5 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 6} 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 socio-demographic 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

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

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

BAME, black, Asian and ethnic minority.

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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 probes 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”

We cannot be cowards: we must learn to see the world from another’s eyes and not place our prejudgement 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.

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'Significant' racial disparities in care of heart patients during first pandemic wave

BAME patients in England less likely than white patients to receive evidence based care

There were 'significant' racial disparities in the presentation and care of heart attack patients during the first wave of the pandemic in England, reveals a large national study, published online in the journal **Heart**.

Patients of Black, Asian and Minority Ethnic (BAME) backgrounds were more likely to be admitted to hospital than their white peers; less likely to receive evidence based care, as indicated by guidelines; and more likely to die early than before the pandemic.

The UK has the highest COVID-19 death toll and the most ethnically diverse population in Europe. During the first wave of the pandemic, BAME patients were twice as likely to die of COVID-19 as white patients.

Health systems around the world have observed a substantial decline in hospital admissions for heart attack and a concurrent rise in early death or complications during the COVID-19 pandemic.

The researchers wanted to find out if the recognised differences in the health outcomes of BAME patients with heart disease worsened during wave 1 of the COVID-19 pandemic in England.

They drew on linked healthcare records from nationwide registries for all patients admitted to hospitals with a heart attack in England between 1 February and 27 May 2020 to see if there were any differences in presentation and treatment between BAME and white patients.

These data were then compared with those of heart attack patients admitted during the same period in each of the preceding three years (2017-19; pre-COVID-19), to quantify any changes in death rates among BAME patients both while in hospital and within 7 days of discharge.

In all, 73,746 patients were included in the final analysis. Of 62,578 patients in the pre-COVID-19 era admitted to hospital, 56,270 (90%) were white and 6308 (10%) were of BAME origin. This compares with 1863 (nearly 17%) BAME patients admitted in 2020.

The number of daily hospital admissions for heart attack also significantly increased among BAME patients in 2020.

During the COVID-19 period, the monthly proportion of BAME patients admitted to hospital with a heart attack increased from just over 16% in February 2020 to nearly 18% in May 2020. This monthly rate didn't change in the pre-COVID-19 era.

Admission rates for heart attack were 65% higher among BAME than among white patients during the COVID-19 period, with similar proportional rises observed for each month compared with the same period in the pre-COVID-19 era.

BAME patients were likely to be younger, male, and to weigh less (lower BMI) than white patients. But they also tended to have higher cholesterol levels, and were more likely to have heart failure, angina, chronic kidney disease and diabetes requiring insulin treatment.

Not only were there differences in the presentation between BAME and white patients, but there were also differences in how they were treated.

BAME patients waited longer than white patients for certain types of invasive procedures and treatment both during the pre-COVID-19 and COVID-19 periods.

And coronary angiography was significantly less likely to be used in BAME patients who were also less likely to undergo PCI (a procedure to restore blood flow).

After adjusting for potentially influential factors, BAME patients were 68% more likely to die in hospital and 81% more likely to do so within 7 days of discharge than white patients during the COVID-19 period than they were during the same timeframe in 2017-19.

BAME patients were also 78% more likely to die than white patients after lockdown started (23 March 2020) than before.

“Immediate counter measures are required to increase patient awareness and promote equity in the cardiac care of this underserved population during the ongoing COVID-19 pandemic,” urge the researchers.

In a linked editorial, cardiologist Dr Shrilla Banerjee, of Surrey and Sussex Healthcare NHS Trust, and colleagues, point out that BAME patients tended to be sicker than white patients which might account for some of the differences in death rates.

But there is no excuse for the differences in the care BAME patients received, they say.

“These observations now fully qualify as evident healthcare inequalities and reinforce disconcerting disparities in cardiovascular care affecting BAME populations,” they write.

“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),” they add.

“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,” they write. But it hasn’t.

“We need to deal with barriers to equitable health, including structural racism and social factors—that is, education, housing and poverty,” they urge.

But doctors must take responsibility too, they write. “We must learn to identify and then remove the impact of bias on our patient outcomes...We must be empowered to draw attention to biased behaviour when we see it and be an advocate for all our patients.”