


Seven Reasons to Care About Racism and COVID-19 and Seven Things to Do to Stop It

 See also Morabia, p. 923, Tarantola et al., p. 925, and the *AJPH* COVID-19 section, pp. 939–977.

The World Health Organization (WHO) has declared COVID-19 a pandemic. Much is still unknown, but as the virus causing this disease has spread, so has misinformation and xenophobia. Unfortunately, this has followed a predictable pattern of connecting people to diseases.¹ The pandemic has reinvigorated old stereotypes of Chinese people and fears of Chinese food, including the notions that they consume pets. Recently, a US senator stated that the “Chinese virus” originated from a “culture where people eat bats and snakes and dogs” (e.g., <https://bit.ly/2yBF10D>). His statement reflects an old belief system linking race and disease. For example, Prince A. Morrow noted in 1898, “China . . . has been the breeding-place and nursery of pestilential diseases, cholera, plague, as well as leprosy, from time immemorial.”^{2(p946)} According to this belief, races are biologically distinct and, therefore, prone to specific diseases or apt to manifest them in unique ways. Such logic was used to justify the infamous Tuskegee syphilis studies and the belief in diseases such as “drapetomania” (the “illness” of slaves escaping their masters).³ Samuel Cartwright and others published articles that espoused a belief that racial minorities were biologically

and socially inferior. Left to their own devices, minorities would ultimately “degenerate” and die off. A major concern for the White population was that interracial marriage would cause degeneration of their race. These concerns in the United States catalyzed the popularity of eugenics, helped establish antimiscegenation laws, justified slavery, restricted immigration, and encouraged deportation.⁴

Although medicine no longer condones such beliefs, ideas from this overtly racist period are still deeply ingrained. This includes believing that racial minorities feel less pain than Whites, sanctioning drugs such as BiDiI that have been approved for only African Americans (and no other races), and using “racial correction factors.”^{5,6} Such practices perpetuate the erroneous belief that racial groups are inherently different.

Because we have never dismantled this belief, admonishing people to recognize race as a social construct is futile. Moreover, it is this belief that allows us to say that COVID-19 is a “Chinese disease” and find comfort in blaming them when little other comfort is available.

WHY SHOULD WE CARE ABOUT RACISM?

First, racism is intrinsically wrong. It contradicts our values as public health practitioners to promote the health of all with the goal of achieving health equity.

Second, racist hate crimes can lead to fear, injury, and death. Even more subtle instances of unfair treatment, such as seemingly minor microaggressions, can contribute to allostatic load and health problems such as heart disease, substance abuse, and suicide among Asian Americans.⁷

Third, discrimination can result in infected persons not being treated properly. Fearing discrimination, infected persons may delay treatment until it is too late. Discriminatory policies and systems that have resulted in the lack of culturally and linguistically appropriate services will likely prolong the COVID-19 outbreak.

Fourth, discrimination can skew our understanding of the disease by affecting the case fatality rate, which is calculated by dividing the number of COVID-19 deaths by the number of diagnosed cases. For example, if people who experience discrimination opt to hide and not get tested, this could result in an undercount of the denominator and contribute to an overestimate of the case fatality rate.

Fifth, anti-Chinese racism has spillover effects to other communities. Most obviously, members of other Asian subgroups (e.g., Vietnamese, Koreans, Japanese) become targets of anti-Chinese discrimination. And racism begets racism, as seen in these racist and anti-Semitic quotations from social media

“The best advice will be to ask Nigerians going in and out of China not to eat bats.”

“. . . because those Mexican murderers and rapists are also at the coronavirus epicenter.”

“My goyim friend, you want coronavirus vaccine? Only 10 million shekel for a limited time only.”

Sixth, racism makes a bad situation worse. Scapegoating

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deflects attention from the underlying fact that our public health infrastructure is underdeveloped. Moreover, the use of phrases such as “Chinese virus” directly contradicts calls from the WHO, the Centers for Disease Control and Prevention, and other scientific agencies to use scientific nomenclature and avoid stigmatizing language. The public receives mixed messages that fuel confusion and panic. Instead, we should be sending consistent messages to help promote facts, encourage salutogenic behaviors, and calm fears.

Seventh, racism and nativism could prevent us from learning from the experiences of China and other countries about community mitigation and preparedness. This unnecessarily prolongs the outbreak and amplifies our losses.

WHAT CAN WE DO?

First, we should amplify our efforts to avoid connecting diseases to social groups. The WHO has issued some helpful tips on this (<https://bit.ly/2S1iW3s>). We should continue to remind our leaders, citizens, patients, and health care providers to avoid discriminating against persons of Asian descent. Of course, this includes avoiding terms such as “Wuhan virus” and “Chinese virus,” but it also includes avoiding certain visual images. Many reports on COVID-19 also include a picture of an Asian person wearing a mask. We should disassociate both the verbal and nonverbal connections.

Second, we need to go beyond words. We need to develop a stronger infrastructure to track discrimination and to swiftly put antiracist countermeasures in place. Reinforcing civil rights and promoting equity is critical as

are our efforts to ramp up the production of test kits, treatments, and vaccines. One example is the US Citizenship and Immigration Services recent exemption that treatment of COVID-19 will not be considered in public charge analysis and, therefore, not harm an immigrant’s application for citizenship. Although this exemption is laudatory, it does not apply to other health conditions (i.e., chronic conditions that put individuals at higher risk for serious complications from COVID-19) and, thus, represents little structural change to promote equity. This exemption should be applied to all health conditions that, if left uncontrolled, would result in preventable hospitalizations.

Third, more than ever, we need science-based education. Schoolchildren need to understand the formulation of race and its intersection with science. Medical education needs a stronger dose of civil rights and a basis in equity. The lay public needs to regain faith in science and facts.

Fourth, we need to reevaluate our compliance with the notion that racial groups are inherently different by reassessing our use of racial correction factors and similarly racialized practices.

Fifth, social media platforms need stronger monitoring of bias and more fact checking. We need to quarantine and eliminate hate speech online.

Sixth, we need to overcome our nativism and do a better job of respecting the research and policies that have been developed overseas. To combat the current pandemic, America’s “best practices” requires us to consider the full range of medical and public health solutions developed around the world; isolation and rejection of solutions based on nativism are shortsighted.

Seventh, we need more research on racism. This includes understanding the social institutions that uphold it and all of the various ways that racism causes and contributes to illness. We need to also understand how hate messages spread. We should find a way to calculate the R_0 (basic reproduction number) to examine the contagiousness of prejudice. We also need to study whether countermessaging efforts actually help; for example, do the WHO recommendations about not stigmatizing actually make a difference?

IN CLOSING

Although prejudice and fear may be common reactions to outbreaks such as COVID-19, they should not be seen as justifiable or even natural ones. Now is the time for solidarity, not slurs. **AJPH**

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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