Life & Times

BAME excess deaths:

chronic stress and constant hostility

Public Health England's review of the disproportionate number of deaths among people of black, Asian, and minority ethnic (BAME) groups[1] fails to identify or tackle the root causes, as reported in the *Guardian*.[2] Social inequality is now a hot topic. Matt Hancock's slowness in coming up with a single practical proposal for saving black lives is an example of discrimination. In contrast, Swansea University Medical School made a statement over the weekend of the George Floyd killing, committing to do more to foster positive change and mutual respect, admitting they haven't always got it right.

NAMING PREJUDICE

On the 'intelligent conversation'[3] podcast, Chris Udenze, a London GP, runs through the complex and multiple factors that may contribute to high death rates among people from BAME groups for almost all causes including: deprivation; not being treated quite right within the health service; epigenetics and generational trauma; vitamin D absorption and not going outside so much; cultural differences in communal or family life. For doctors who died from COVID-19, a pecking order for PPE, growing up abroad, or little immunity to coughs and colds could be factors. He also remarks on the obvious but apparently unmentionable 'social factors'. We have, as a society, difficulty in naming prejudice. He also gently spells out how it is *to always be seen as 'other'*.

Every one of us in the health service has overheard and witnessed unacceptable rudeness, sly put-downs, exclusion, or smiling say-the-opposite-of-what-you-mean British insincerity. Thirty years ago in Brixton and still now, I see people berate their professional carer or nurse when they are of Caribbean heritage. I see my non-white colleague meet an edge of hostility with some patients most days, while I am conferred authority and respect.

A King's Fund report,[4] last November, attempts to describe what discrimination looks and feels like. A thoughtless word,

Sarah Evans

unhelpful language, where or with whom we choose to sit down. Multiple and sustained micro-aggressions themselves may contribute to increased susceptibility to COVID. There is a clear mechanism: stress, cortisol, diabetes. Chronic stress also causes reduced immunity. A 2017 review[5] shows that small, often unintentional discriminations are linked to heart disease. Additionally, they result in unhealthy behaviours and act as barriers to care. Small prejudices can amount to 'death by a thousand cuts'.[6] These daily discriminations will exacerbate factors such as lower-paid roles and overcrowding, but they also have their own direct effect on health, immunity, and susceptibility to illness.

SYSTEMIC PREJUDICE *IS* A WHITE ISSUE

Diversity training with evaluation for effectiveness, and, as Chris suggests,[3] monitoring to demonstrate inequality, would be a start to tackle these deeply embedded social factors in the health service as within the police. This prejudice is a white issue and we all individually need to own it. I haven't learnt how to monitor my own language and behaviour adequately to avoid hurt and exclusion. Nor have I, the way I know my peers of black and Asian heritage have had to, learnt to 'say something', in a non-confrontational way, without accusation.

Amanda Wright, on a BBC video,[7] reminds us that, like everyday sexism, discrimination may masquerade as friendly joshing. As bystanders, we must learn to challenge such comments, to explore ideas or implications, and not let the moment go by unacknowledged. We need to stand with them — silence is violence. First, importantly, we need to acknowledge that it is happening. Finally, there *is* no mysterious genetic or melanin fault causing excess deaths among health workers of colour; rather, it is the way we allow prejudice to fester in the fabric of NHS life.

"Every one of us in the health service has overheard and witnessed unacceptable rudeness, sly put-downs, exclusion, or smiling say-the-opposite-of-what-you-mean British insincerity."

Sarah Evans,
Retired GP, Berkhamsted.
Email: sarahevans78@hotmail.com

This article first posted on *BJGP Life* on 16 June 2020: bjgplife.com/BAMEdeaths

DOI: https://doi.org.10.3399/bjgp20X712145

REFERENCES

1. Disparities in the risk and outcomes of COVID-19. 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf (accessed 6 Jul 2020).
2. Siddique H, Halliday J. 'Reeks of hypocrisy': what UK's minority ethnic MPs say about Covid-19 death toll. *Guardian* 2020; **5 Jun:** https://www.theguardian.com/us-news/2020/jun/05/reeks-of-hypocrisy-what-uks-minority-ethnic-mps-say-about-covid-19-death-toll (accessed 23 Jun 2020).
3. Dr Chris Udenze. Intelligent conversation with Marceline. 4 May 2020. https://www.youtube.com/watch?v=C-I0EP7eK8E (accessed 23 Jun 2020).
4. Ross S. *'We're here and you're there': lived experiences of ethnic minority staff in the NHS. 2019*. London: King's Fund, 2019. https://www.kingsfund.org.uk/blog/2019/11/lived-experiences-ethnic-minority-staff-nhs (accessed 23 Jun 2020).
5. Torino G. How racism and microaggressions lead to worse health. *Center for Health Journalism* 2017; **10 Nov:** https://www.centerforhealthjournalism.org/2017/11/08/how-racism-and-microaggressions-lead-worse-health (accessed 23 Jun 2020).
6. Yoon H. How to respond to microaggressions. *New York Times* 2020; **3 Mar:** https://www.nytimes.com/2020/03/03/smarter-living/how-to-respond-to-microaggressions.html (accessed 23 Jun 2020).
7. BBC. How I deal with microaggressions at work. 2019. https://www.bbc.co.uk/ideas/videos/how-i-deal-with-microaggressions-at-work/p07sc5vb (accessed 23 Jun 2020).