Medical News & Perspectives

Taking a Closer Look at COVID-19, Health Inequities, and Racism

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Amid the historic convergence of the coronavirus disease 2019 (COVID-19) pandemic and antiracist activism in the US, *JAMA* spoke with Chicago public health legend Linda Rae Murray, MD, MPH. In the Juneteenth conversation, Murray said the pandemic glaringly exposed health inequities and systemic racism. The Minneapolis police killing of George Floyd, an unarmed black man, further pulled back the veil on institutional racism in law enforcement, which medical organizations say is a social determinant of health (**Video**).

Meanwhile, the COVID-19 crisis also revealed the nation's eroding public health readiness, according to Murray, an adjunct assistant professor at the University of Illinois at Chicago School of Public Health and a past president of the American Public Health Association.

"Most big health departments have under 30 contact tracers—how is that possible?" she said. "Our laboratory system has been decimated," she added. "When I first did my residency, most state health departments and local large health departments had their own labs. Most of those are gone now."

Audio and Video

Murray speaks from a deep well of experience. Over her decades-long career, she worked as bureau chief for the Chicago Department of Health under the late Mayor Harold Washington, medical director of the federally funded health center serving the Cabrini-Green public housing project, and chief medical officer for suburban Cook County's public health agency.

The following is an edited version of the conversation with the 71-year-old Murray, who recently retired from clinical practice after more than 40 years as a general internist. It ranged from COVID-19 in minority communities to the nation's public health capacity to police brutality against people of color.

JAMA: In the US, black people account for 13% of the population, but 24% of COVID-19 deaths where race is known. And blacks, Latinos, American Indians [and Asian Americans] also represent a disproportionate number of cases. Can you talk about some of the many factors that are driving these numbers?

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DR MURRAY: This global pandemic gives us an opportunity to really look carefully at health inequities. A lot of people blame the differences in health status on people's personal health behaviors. And certainly those are critically important. Like most physicians, I spent time with my patients working on those difficult things—stopping smoking, watching your diet—all those things. But what we understand more and more is that the structural factors—how the country votes, whether or not people have medical insurance, whether or not people are able to get sick days—these are all things that influence individual health and health of populations in profound ways, certainly more than just their individual personal habits.

Yes, if you have a comorbidity, that's an issue. But the essential workers.... And let me be clear who that is. Yes, they are doctors and nurses and people that are working in health care. But they're also people that are stocking the grocery stores and delivering the Amazon packages and running the subways and the bus lines. These essential workers in the main are underpaid, low-wage workers who often don't have sick time, and so they have a special pressure to go to work.

In the Chicago area, the parts of our area that have high numbers of essential workers—on the South Side, the southwest side, the western suburbs—match very well with low-income working-class communities and black and brown communities. So I would argue that all of these structural factors, the things that force people to have hypertension, like racism; the jobs that people are forced to have; the fact that if a member of the family gets sick, they don't have a guest house or a basement for someone to stay in; that you have multigenerational households in relatively small spaces.... All of these structural factors really help account for these horrible differences in case rates and death rates.

JAMA: Something that has been discussed is that the idea of working from home is a privilege that a lot of people don't have.
DR MURRAY: Absolutely. If your job is restocking grocery shelves, you can't do that from home. There are other realities, too. The issue of digital divide is very real. In black communities and brown communities, even if you can afford Wi-Fi, it's not always there. So, yes, working from home is a privilege. Most people cannot really do it. Even when they can, there's a real problem with doing it. What if you have 3 kids and, if you're lucky, you might have 1 computer? So I think the notion that we've solved everything just by doing everything through Zoom is a mistake. That's not reality and people are going to be suffering because of that.

JAMA: Back in April, a young [black] man on Chicago's northwest side held a house party to memorialize 2 friends who were killed by gun violence, and this was when the city was on full lockdown. He was very publicly shamed. He went on to apologize and to say that he hadn't seen much information on the dangers of the coronavirus. This seems like a major failure of public health messaging. Do you feel that Chicago—and the nation, for

that matter—did enough to get the message out to minority communities, including the African American community?

DR MURRAY: I think the question becomes: what message went out? And how did it go out? When we give messages, we have to try to be clear. Not only clear about what we know, but also clear about things that we don't know. To the extent that the advice that has come to the public changes without a full understanding of why it's changing, to the extent that our political leaders cause more confusion than shed light on what's going on—I think it confuses people.

The other thing I have to say is, young people are young people. I think we have to be a little careful about the shaming. I think it's horrible that that party took place. And I feel sorry for those young people. They clearly didn't fully understand what was going on.

We have to find ways to talk to each generation. They're not going to be watching the evening news or CNN. They're on social media and other things. Since that event, as the pandemic has gone on, we've seen that lots of people, like Common, one of our local rappers, and other stars both of sports and music, have come out to try to help explain this. I thought it was really important that Dr [Anthony] Fauci came on Trevor Noah's program and had a session with Stephen Curry. I think you have to form your message so that it reaches the audiences you need to reach. So we have 1 message for old people like me and another message for young people.

JAMA: Do you think that the messaging has improved and that more people are being reached now?

DR MURRAY: I think more people are being reached only because this has gone on for 3 months now. But I think our messaging has not improved as much as it needs to. If a vaccine is ready in 2021, I think it will be close to a miracle, especially if you mean it's actually in people's arms. I think we have to tell people that this is how long vaccines usually take. Even if we discover 1 or 2 effective vaccines by 2021, it will take another length of time before we have enough supply and distribute it around the world. That message has to go out, and it has to go out repeatedly all of the time, so that people have realistic expectations and they can make adjustments for that. That means we have to, as physicians, be willing to say that we don't really understand this pandemic completely yet and we don't understand everything this virus does. These are the things that we're trying to do around the world to understand it, and here's what we can do collectively, as a community, in this present time.

JAMA: Dr Patrice Harris, the immediate past president of the American Medical Association, has said that she has been trying to dispel a misconception among the African American community that black people can't get COVID-19. Do you have any idea where this myth arose, how pervasive it's been, and potentially, how detrimental?

DR MURRAY: You have to think about who from America and Europe goes to China. Not working-class people, black people on the South Side of Chicago. In the very beginning, people who were working in China, people that were tourists in China, people that were engaged in world travel were the first few people in the United States that got the disease. And so, then it gets in people's minds, "Well, I don't know anybody with the disease, so it must not be happening in the black community." Today, surveys have been done and more black people know someone who has been sick, or in the hospital, or died from COVID-19 than white Americans. So, I think today that myth is not a problem in the black community.

Similarly, people here in Chicago, in Pilsen and Little Village, a predominantly Mexican community, in the early days said, "Mexicans can't get this. That's something that's happening to black people." And we know today in Chicago the Latinx community has the highest number of people with COVID-19.

Communities without accurate information invent explanations for what's going on. There are also conspiratorial theories, just like we saw with HIV. And as physicians, we have to deal with that honestly and openly. This is something that always happens with pandemics. We have an obligation, as clinicians, to give the information as accurately as we have it and to entertain people's questions and not just dismiss them.

JAMA: What about distrust of the medical establishment in the black community? Do you feel that's had a bearing on the COVID-19 pandemic?

DR MURRAY: That's always a problem. It is real, and it's hard to say that people are wrong for having a level of distrust. Both of my parents have been dead for a few years, but I remember when they were still here, sitting at their table, trying to help them figure out what Medicare plan to sign up for, and trying to convince them to get certain preventive things like flu shots. They stopped and looked at me and they said, "Linda, we don't trust doctors, and we haven't forgotten that you're one of them."

I think that African Americans have every right to distrust clinical medicine, and not just for Tuskegee, but for the structural racism in medicine as an institution—in our hospitals, and our health clinics, and our insurance plans—and how we talk about and think about people of color and black bodies. It's a constant reminder that we are viewed "lesser than" and then perhaps we're not quite human.

Fortunately, people tend to like their own physician if they keep going to them, no matter what race they are. But that doesn't mean they trust the institution. And that's why I think it's so important that we not have a higher-than-thou attitude on how we deal with people. We really have to not be judgmental; we really have to try to understand the real-world struggles that people have in following instructions and thinking about how to make themselves healthier.

There's distrust in the white population, too. Most of the anti-vaxxers tend to be white Americans. So we really have to find a better way to communicate with people that live in this country and gain their trust. And I think that starts by admitting what we know and what we don't know and having a reasoned conversation about what people need to be concerned about and what not.

JAMA: When we do have a vaccine, are you concerned about whether it will be available for minority communities?

DR MURRAY: Absolutely. People have been hospitalized and sent home and told that they don't have to worry about that COVID-19 hospitalization. They go home, they need oxygen, and all of a sudden, they have a giant bill. It may not seem giant to someone who is a physician, but $200 to $300 is a huge bill for many, many working-class families. So they're supposed to have home oxygen, but they can't afford to pay for the oxygen. It is a crime that the richest

country in the world cannot provide medical care for everyone in our borders. I do think that this is going to continue to be a problem and getting a vaccine is part of that. There should be no barriers to getting the vaccine.

JAMA: ProPublica reported that of the first hundred people to die from COVID-19 in Chicago, 70 of them were black. The article pointed out that a lot of people in the black community in Chicago waited to go to the hospital because they didn't have faith in the lower-resource safety net hospitals in their neighborhoods. What are your thoughts on that?

DR MURRAY: I think people know intuitively that we are an underresourced community. People also have other realities. If I go to the doctor and I can't work for a week, what does that mean? Especially early, before unemployment stipends were put in place, this was a real problem. It will continue to be a problem. People have lots of real-world reasons. Who's going to take care of my mother if I go in the hospital? Who's going to take care of my children? If we're going to address this pandemic appropriately, we have to put those structural supports there to support people. You can't ask someone to isolate for 2 weeks because they're infected and not provide them with a way to do that.

JAMA: What do you think about the lack of demographic data that we've been experiencing?

DR MURRAY: This is something that hurts me to my heart as a public health person. We have allowed, over the past 25 years, the public health infrastructure that existed in this country to crumble. In the past 20 years, we've lost a quarter of a million public health workers. We've lost many of our public health nurses that really were entrenched in the community, went door to door, talked to people. We have a system that's like a rusty bridge with holes in it that we're trying to combat this pandemic with. I hope one of the things that we learned from this is we cannot allow our public health infrastructure to decay like this. This is critical to survival of the nation.

The other thing we're missing critically is active surveillance. It's not enough to know a year from now where the disease happened. We want to know right now so that we can respond immediately. That really requires a system of active surveillance with rapid turnaround with staff that know what they're doing. There are 3000 health departments in this country and less than one-third of them have even 1 epidemiologist on staff. That's criminal, and that's because we've decided to cut government workers and we decided not to invest in public health. That's like we have a fire going on and we've defunded the fire department.

JAMA: We are at another reckoning over race and racism in this country. An estimated 1 in 1000 black men in the US will be killed by police over the course of their lifetimes, according to data, and the risk is also greater for other people of color. As a physician, how do you think about this in the context of keeping communities healthy?

DR MURRAY: I am a mother of a black man. He's 49 years old now, but I still have terror in my heart if I know he's going out. When he was younger, it was true terror, and I would not feel any relief until he came back in the house. There is no way to overstate the terror that lives in the hearts of black mothers all over the country. And to see George Floyd murdered in front of you on TV.... It's something that I intellectually understand happens. But now when it can be visibly taped, and when police can know they're being filmed and still continue to murder people, I can't even describe the kind of rage that I feel. It is impossible for a family—a black or brown family, a Native American family—or community not to be terrorized by that reality.

We've had this problem in our country for centuries and I hope that Americans come to grips with what we mean by structural racism. I can't tell you the surprise I felt in 2008 when the American Medical Association apologized to the black community and black physicians, but we have to go beyond just an apology. We have to really work together to change how we educate our physicians and other health care workers. We have to work together to change the face of our profession. We have to work together to change how we think about and diagnose disease. We have a lot of power, and authority, and respect as physicians, and we know what we need to do to have healthy communities. We need to speak out forcefully and strongly and say, "No, this is what we need to do to have healthy children in our schools, this is what we need to do to have healthy seniors in our communities." We know what to do. We just have to come together and begin to do it. ■

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