The harms of police frisking in times of a pandemic

The lack of personal protective equipment (PPE) among healthcare workers in the UK has been an integral part of the debate on the UK Government’s failure in dealing with the COVID-19 pandemic. Similar to the close contact that is expected between patients and healthcare staff, which could put both at risk of transmissible disease in the absence of appropriate measures, members of the public can also come in close contact with police staff during the process of frisking. The chances of being stopped and frisked by the police are dramatically (up to 10 fold) increased for Black, Asian, and Minority Ethnic (BAME) individuals in the UK who are also disproportionately affected by the risks of COVID-19.

On the afternoon of June 11, 2020, I was stopped by two officers from the Merseyside Police Force in Liverpool, UK. The officers were wearing civilian clothing and claimed that I had been walking at an unusually slow pace, which had seemingly raised their suspicion. The officers kept very close to me as I was being questioned, despite my pleas to keep a 2 m distance. They then attempted to do a full body search. I was surprised that they were going to search me without using PPE, so I demanded that they at least wear gloves if they were to search me. Because the officers had no gloves at the time, I was walked to a police van about 200 m away where PPE was available. I was forced to enter the police van, which had other personnel inside it who also were not wearing PPE. One of the officers picked a pair of gloves with their bare hands and handed them to another officer who wore them and immediately started frisking me without disinfecting them.

The official guidance on the use of PPE among the police force in the UK recommends their use to protect police staff but critically, the four-page document pays no attention to the safety of the public who are especially exposed during body searches. I made an official complaint to Merseyside Police about the health risks involved in their current stop-and-search practices. The police informed me that they will make sure sure police use PPE more properly in the future, but I did not receive an apology.

I was speaking in Arabic on the phone when I was stopped. The two officers seemed very interested in my origins, asking where I was from on multiple occasions. In the UK, stop-and-search is only authorised on reasonable grounds. Whether walking pace, spoken language, or refusal to answer where one is from is counted as reasonable grounds to stop and search somebody is perhaps a personal judgement. To me, this incident displayed an alarming synergy between the evidenced institutional racism in the British police force, the disproportionate vulnerability of BAME individuals to COVID-19, and the police’s apparent preferential interest in the safety of its own, disproportionately white British staff, over the public’s safety.

A review of the UK police’s stop-and-search practices during the COVID-19 pandemic is urgently required. George Floyd’s chilling last words “I can’t breathe” might well be uttered in hospital wards by a different victim as they literally suffocate from a disease that was brought to them by no more than a casual police search for a mere bag of cannabis.

I declare no competing interests.

Ghaith Aljayyoussi
ghaith@lstm.ac.uk
Liverpool School of Tropical Medicine, Liverpool L3 5QA, UK

1. Horton R. Offline: COVID-19 and the NHS: “a national scandal”. Lancet 2020; 395: 305-302.
2. UK Home Office. Police powers and procedures, England and Wales year ending 31 March 2019. Oct 24, 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/841408/police-powers-procedures-mar19-hosb2519.pdf (accessed June 24, 2020).
3. White C, Naifyan V. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. May 7, 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroup/englandandwales/20200302to10april2020 (accessed June 24, 2020).
4. National Police Chiefs’ Council, College of Policing, National Police Coordination Center. Personal protective equipment (PPE) operational guidance, 2020. 2020. https://www.college.police.uk/What-we-do/COVID-19/Documents/Personal-Protective-Equipment-Operational-Guidance-1.pdf (accessed June 24, 2020).
5. UK Public General Acts. Police and Criminal Evidence Act 1984, 1984, part 1. 1984. http://www.legislation.gov.uk/ukpga/1984/60/part/1 (accessed June 24, 2020).
6. Holdaway S, O’Neill M. Institutional racism after Macpherson: an analysis of police views. Policing and Society 2006; 16: 349-69.
7. UK Home Office. Police workforce, England and Wales, 31 March 2019, second edition. July 18, 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831726/police-workforce-mar19-hosb1119.pdf (accessed June 24, 2020).

The health-care sector’s role in climate stabilisation

Nick Watts and colleagues’ 2019 report of the Lancet Countdown on health and climate change leaves no doubt that global warming will heavily affect every child born today. Young people—the generation that will have to live through the consequences of a warming world for the longest—are actively taking part in raising awareness for climate change. Inspired by the Fridays for Future movement, thousands of young people have been doing everything possible to bring about social change towards a sustainable ecological lifestyle.

As Rockström and colleagues suggested, time is running out, and climate stabilisation should become established in global governance alongside economic development, human rights, democracy, and peace. We believe that as doctors and medical educators, not only are we well
placed to inform the public about the consequences of climate change, but we also have an obligation to do so. At the Heidelberg Medical Faculty, we assessed individual and professional responsibility, as well as awareness for the consequences of climate change (unpublished). We found that of 65 medical students in their final year who recognised these consequences and their individual responsibility as global inhabitants, most were unaware that the medical profession bears a responsibility of being an ecological advocate and role model in the face of the threat to global health posed by climate change. This absence of awareness is why addressing climate change in the medical curriculum is so crucial, and long overdue.

We declare no competing interests.

*Till Bugaj, Anna Cranz, Christoph Nikendei
till.bugaj@med.uni-heidelberg.de

1 Watts N, Amann M, Arnell N, et al. The 2019 report of the Lancet Countdown on health and climate change: ensuring that the health of a child born today is not defined by a changing climate. Lancet 2019; 394: 1836–78.

2 Rockstrom J, Gaffney O, Rogelj J, Meinshausen M, Nakicenovic N, Schellnhuber HJ. A roadmap for rapid decarbonization. Science 2017; 355: 1269–71.

The health-care sector is increasingly recognised as a major contributor of greenhouse gas emissions. We thus welcome the 2019 report of the Lancet Countdown on health and climate change, in which Nick Watts and colleagues’ provide a new global comparison of greenhouse gas emissions from health care (indicator 3.6).

The report shows that, per capita, greenhouse gas emissions from health care between 2007 and 2016 have increased in all but one country (Greece) and suggests that these findings are in agreement with our international comparison of health care carbon footprints in annual time series from 2005 to 2014, which was published in 2019.3

In fact, we found that health carbon footprints declined in 14 countries in this time period, including in the UK,4 which was mostly due to decreasing emission intensities in the energy sector. However, Watts and colleagues’ assume constant greenhouse gas intensities to extrapolate greenhouse gas emissions from health care on the basis of real health expenditure, ignoring technology development in the time period. Therefore, their method cannot reflect the observed changes in greenhouse gas intensities in the supply chain of health care.

Particularly in connection with the health-care system, the context of observed or intended reduction in emissions is important, as these reductions should not be at the expense of health care. This was the case, for example, in Greece, where large cuts in public health expenditure led to a reduction in emissions, but also to a reduction in health-care provision.5

We encourage the Lancet Countdown investigators to update their method for assessment of greenhouse gas emissions to include change in technology and provision of health service in future assessments of mitigation options of health-care sectors.

We declare no competing interests.

*Helga Weisz, Peter-Paul Pichler, Ulli Weisz, Ingram Jaccard
weisz@pik-potsdam.de

Authors’ reply

We thank Till Bugaj and colleagues and Helga Weisz and colleagues for their comments.

Climate change threatens to undermine the past 50 years of gains in public health, and the health community has an ethical responsibility to lead by example as it mitigates the effects of climate change and adapts in response to this challenge. We welcome the Correspondence from Weisz and colleagues, and acknowledge their work and expertise in this emerging field. Their work suggests that health care in the countries of the Organisation for Economic Cooperation and Development (excluding Chile) along with health care in China and India contributed approximately 4.4% of global carbon dioxide (CO2) emissions in 2014.6 This overall estimate is similar to the estimate of 4.6% that we presented in the 2019 report of the Lancet Countdown on health and climate change,7 which included an expanded set of countries and regions. Moreover, both analyses emphasise a profound gap in health-care emissions per capita between high-emitting and low-emitting countries (eg, the gap between the USA and India).

Weisz and colleagues note important differences in country-specific results between the two assessments, which stem from the different methods taken to consider temporal changes. Pichler and colleagues’ produced results for 2000–14, for countries in which data on health expenditure were available, using a dynamic set of environmentally-extended multi-region input-output (EE-MRIO) tables in the EORA model (which captured CO2 emissions only).8 To align with the Lancet Countdown’s mandate of monitoring the evolving health profile