We are colleagues and friends working together in busy emergency departments (EDs) in Washington, DC. As black physicians working in urban America, we do not find the recent deluge of news reports chronicling the disproportionate effect that the coronavirus disease (COVID-19) pandemic is having on the disenfranchised and minority populations in our country shocking. We have long been witness to and are in a constant state of alarm over the legal, medical, educational, social, and economic inequities faced by the most vulnerable residents of this country.

As this epidemic is showing all of us, the disease may vary, the particular population might be different, the name of the city or town can change, but the outcome is almost uniformly predictable. COVID-19 has highlighted racial and ethnic inequities. We can all see them in the daily, undeniable numbers that flash at us from our phones and television screens. We are grateful to the press for illustrating the statistics with poignant, often personal stories that highlight the acuity and indecency of these inequalities.

Like all emergency physicians, we not only worry about the patients we treat on a daily basis with COVID-19, but we also worry about our families at home. Yet further, for us this pandemic takes on a deeper meaning. Our hometowns are the cities that are facing some of the largest tolls in COVID-19 cases among people of color. When a black, Latinx, or Native American “person under investigation” for COVID-19 comes into the ED, we not only see our patient, but we also see our mother, father, aunt, and uncle. We realize that we are among the lucky ones. We have regular jobs in the medical sectors with some stability during this pandemic. We also have a place to call home, a regular means of transportation and the ability to practice effective social distancing.

Many of our black and brown patients are too sick to be discharged, showing signs of severe illness upon arrival to the ED and rapidly decompensating over a few hours to several days despite our best efforts to provide critical care. As the media has highlighted, the alarmingly high rates of COVID-19 deaths among communities of color could be due to chronic diseases such as hypertension, diabetes, and coronary artery disease. Many of these illnesses that predict poorer outcomes for COVID-19 may cause providers to deem care futile. As noted by Chomilo et al., resources that rely solely on clinical guidelines can place patients of color, who have higher rates of chronic disease, at a disadvantage. This can be further complicated by the implicit bias that may impact provider decisions about allocation of the receipt of critical care. We also know that crucial social determinants of health, such as ready access to nutritious foods, outdoor spaces to exercise, secure housing, and regular income, are disproportionately lacking in many predominately ethnically minority communities. It is most ironic that members of these communities are also disproportionately represented in the service industries that have continued to extensively support our nation as white collar workers shelter in place.

To decrease these inequities, we need more than just additional data, increased testing, and expanded access to medical equipment. If we concentrate solely on building a system that better prepares us to detect and control future pandemics or if we only use our resources to build a huge national stockpile with which to combat future scourges, we stand the risk of failing our most disadvantaged populations over and over again. We cannot ignore the urgent need to address the social determinants of health that are reflected in the lack of resources present in certain communities and are associated with increased morbidity and mortality. We must design health care solutions that are nuanced enough that we are able to address health disparities while improving health outcomes for all patients. For example, appropriate as

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they are, social distancing mandates and increased testing for COVID-19 will not yield the expected outcomes if we do not make tangible efforts to address the clear patterns in racial disparities that have emerged.

The Robert Wood Johnson Foundation has noted that to improve health for all communities, we must build a “culture of health.” This means thinking broadly about approaches that address health and well-being across all social domains. In addition to supporting strong access to care, we must create safe spaces for individuals to live and exercise as well as provide healthy food options, equitable transportation, a clean environment, and address the racial wealth divide. It is difficult to socially distance if your city does not have an adequate transportation structure in place to get to work. It is difficult to socially distance if your job has limited workspace and you fear the consequences of calling out sick. If there are no grocery stores in your area, trying to stand 6 feet apart in a convenience store is not realistic. And if you are homeless and get COVID-19, you cannot stay in your apartment waiting to get better from the illness. If you do have a home but live in a multigenerational household, as do approximately a quarter of all black, Latinx and Asian American residents, it is difficult to go home without infecting your family. Public health recommendations do not fully address the realities that people of color are experiencing. COVID-19 has highlighted many of the social disparities that exist for communities of color.

As Dr. Anthony Fauci has stated, this pandemic “ultimately [shines] a very bright light on some of the real weaknesses and foibles in our society.” It is time that we address the social issues that lead to the alarming rates of COVID-19 in our communities. We hope that in doing so, we can also improve the social infrastructure that are at the root of some of the disparities we are seeing today. Let us not just shake our heads and say how awful things are without initiating change. Let us use this opportunity to design long-term solutions.

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