Chapter 13: Health, Racism, and COVID-19

In 2015, the World Health Organization issued new best practices for naming infectious diseases. In particular, it recommended that scientists, media, and national authorities use generic descriptive terms rather than the names of associated places, people, or animals because of the negative effect this can have on economies, nations, and people. On February 11, 2020, the WHO followed these guidelines when it officially named the novel coronavirus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" and the disease it caused "COVID-19" (19 stands for the year it was discovered, 2019).

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Unfortunately, the new guidelines didn't stop some politicians (including the US president) and media from coming up with or spreading other names for the virus, in direct contravention of WHO recommendations: the "Chinese flu," the "China flu," the "Wuhan virus," and most problematically, the "Kung Flu."

The association of the disease with its country of origin increased anti-Asian sentiment in the West at a time when international cooperation was vital to control the pandemic and work on treatments and vaccines. This likely played a role in the spread of conspiracy theories in both China and Western countries about where the virus actually originated and how it was spread. It also sparked incidents of racism in the US and Canada. A survey of 500 Canadians of Chinese ethnicity by the Angus Reid Institute and the University of Alberta found that 50% had been insulted or called names during the pandemic, and 43% had been threatened or intimidated. Yet again, despite the WHO's best efforts, an infectious disease had been racialized and had become a vector for racism.

During the pandemic, health units gave explicit direction to people regarding what to do if they thought they had COVID-19. In effect, they had to resocialize what we do when we get sick. In Canada, we are used to going to work when we are sick. If we feel really bad, we book an appointment to see our family doctor. The nearly 4.8 million Canadians without a family doctor show up at walk-in clinics or hospitals without appointments. During the pandemic, these behaviours risked spreading the disease and overwhelming our medical system. In their place, medical authorities recommended a number of new procedures: self-assessments to check for COVID symptoms; calling hotlines for more information; staying home and self-isolating with mild symptoms; and calling rather than visiting family doctors for other medical concerns. And, of course, not going to work if you're sick! Such changes revealed social patterns we may not have noticed pre-COVID. Whether they change the way Canadians interact with their healthcare system for good (or for worse) is yet to be seen.

As you read the chapter, consider the following questions:

- Having an underlying condition can increase your risk of getting a severe case of COVID-19. These conditions are called comorbidities. Confirmed comorbidities include chronic kidney disease, obesity, heart diseases, and type 2 diabetes. Other possible comorbidities include asthma, high blood pressure, liver disease, pregnancy, and smoking. The full list and the CDC's recommended actions for people with comorbidities can be found here. Knowing you are more susceptible to a disease is valuable information. However, in the context of Emke's sick-role expectations, is there a danger that such lists might contribute to our inclination to blame individual "choices" for getting sick? How do you balance the risks and benefits of providing such information? Explain your answer.
- What is the regular social course when you have the flu? Now compare that to the social course experienced by people who may have COVID-19 (you can base this partially on *The Globe and Mail's* list of recommended procedures). How do they differ?
- In the chapter, we discuss how people of Asian ethnicity were blamed and discriminated against during the 2003 SARS outbreak. What are some similarities and differences between what has happened with the COVID-19 pandemic?
- There is evidence to suggest there may be long-term health effects for those who contracted COVID-19 and "recovered." These may include strokes, heart damage, lung damage, and neurological damage. Describe an impairment and an associated disability that a person with one of these long-term health effects may have.

Additional online resources

Not all of the pandemic's effects on health could have been anticipated. Have you noticed any surprising effects in your life?

- Bradley, L. (2020, April 27). *If you have anxiety and depression but feel better during coronavirus, you're not alone*. Daily Beast.

An incident on a bus showed the effects of racialized disease names in action, but with a positive ending.

- Chiu, J. (2020, July 9). *She was watching another racist incident on a Vancouver bus. And then, something different happened*. Toronto Star.

Many people go to work when they're sick because they don't have paid sick leave (or they've run out of a limited number of paid sick days). How has this problem been exacerbated by the pandemic?

- Matulewicz, K., & Fariey, D. (2020, June 1). *Workers need paid sick days. Here's how to do it*. The Tyee.

The chair of diversity, equity, and inclusion for pediatrics at Yale School of Medicine explains why language is important when describing diseases and patients.

- Vazquez, M. (2020, March 12). *Calling COVID-19 the "Wuhan Virus" or "China Virus" is inaccurate and xenophobic*. Yale School of Medicine.

These two articles situate anti-Chinese racism during COVID-19 in the context of historical racism against Chinese people in Canada.

- Larsson, P. (2020, March 31). *Anti-Asian racism during coronavirus: How the language of disease produces hate and violence*. The Conversation.
- Wong, E. H-S. (2020, February 3). *When a disease is racialized*. Briarpatch.