# Using the right words to address racial disparities in COVID-19

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Reports continue to show prevailing racial inequalities in COVID-19 outcomes.[1] However, most of these reports rely on language that is not necessarily constructive or appropriate in framing how racial health disparities are experienced in terms of who is affected and how social structures contribute to these resulting inequalities. We propose three ways in which we can steer scholarly discussion surrounding racial inequalities and COVID-19 that better encapsulates those affected and why.

First, we call for the replacement of the acronym BAME (Black, Asian, and Minority Ethnic) in research on race, ethnicity, and COVID-19 with the term racially minoritised. Many scholars have described the problematic use of BAME, including its lack of specificity,[2] emphasis on skin colour,[3] and that few racially minoritised people identify with the acronym.[4] The term minoritised, coined by Yasmin Gunaratnum in 2003,[5] provides a social constructionist approach to understanding that people are actively minoritised by others rather than naturally existing as a minority, as the terms racial minorities or ethnic minorities imply. The term racially minoritised confirms that so-called minoritisation is a social process shaped by power.[6] Racial disparities in COVID-19 outcomes in the UK, including higher likelihood for racially minoritised people than white people to have pre-existing conditions, conduct essential work, and live in poverty, are due to the existing racial hierarchy rather than skin colour. This new term would acknowledge these differences in ways that BAME and other terms such as racial minority and person of colour do not.

Race refers to perceived biological difference linked with physical characteristics such as skin colour and hair texture, whereas ethnicity refers to perceived cultural differences between groups. Although some groups are perceived as primarily racial (eg, Black people), or primarily ethnic (eg, Asian people), and some race-ethnic (eg, Black Caribbean people), a racialised component exists in all these groups' perceived differentiation to other racial groups. For instance, even though the term Asian is based on ethnic origin, beyond this cultural component there is also a connected perceived biological component associated with the term that posits Asian people as different to Black, Latino, Indigenous, and white people. Therefore, we advocate for use of racially minoritised as an appropriate term that refers to those who have the same shared experience, apart from white individuals, of exposure to systemic and individual racism in health and beyond.

Although we support the use of racially minoritised, we are cautious not to dismiss the use of racial categories with which people identify, such as Black, Asian, Latino, Indigenous, and mixed race. Differential outcomes in COVID-19 for different racially minoritised groups need to be studied, documented, and addressed.

Rayvenn Shaleigha D'Clark states of BAME, "The acronym continues to reduce the identities of victims of white supremacy to a single, three to four-letter abbreviation whilst remaining divorced from the long history of racial subjugation."[7] This statement brings us to our second recommendation, which is to include the term white privilege when speaking about COVID-19 disparities and other health differences between white and racially minoritised people. Speaking solely about disparities often renders who is responsible for the disparity and who the disparity exists between invisible. That is to say, it is not just racially minoritised people who are disadvantaged in terms of COVID-19 outcomes. White people have made (conscious and unconscious) decisions that have resulted in these outcomes and are simultaneously benefitting from their dominance in the social hierarchy in terms of reduced exposure and access to superior medical care. However, white people might be disadvantaged because of other minoritised identities relative to ethnicity, gender, socioeconomic status, religion, sexuality, and disability.

We also suggest continued use of the word racism when discussing COVID-19 racial health disparities. Too often we whittle down racial disparities to class disparities or unknown forces. We must recognise that the mechanisms of racism have contributed to the differential outcomes between racially minoritised and white people in COVID-19.

Finally, when researching racial disparities and COVID-19, we call for widespread use of the word intersectionality and to give credit to those who

developed this theory. Scholars have shown the importance of understanding COVID-19 outcomes in an intersectionality framework.[8] Understanding racial disparities in COVID-19 also requires that we consider power dynamics connected with race, such as gender, socioeconomic status, religion, sexuality, and disability. When enacting an intersectionality framework, scholars need to recognise those that were instrumental in its creation, such as Kimberlé Crenshaw[9] and Patricia Hill Collins.[10] Far too frequently we see the theory, or its tenants, being used without proper attribution to these racially minoritised women.

COVID-19 has brought previously unaddressed racial health disparities to the forefront of both scholarly and public conversation. It is up to us to discuss these issues using the most constructive and appropriate language to best address health inequality between racially minoritised and white people. Now more than ever, it is no longer an option but a necessity to drive meaningful change in the area of racial health disparities on individual and systemic levels for the benefit of all in society.

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