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Transcription results:

JW: Jazzmin Williams

JT: Jenny Tsai, MD, M.Ed

RK: Rohan Khazanchi, MPH

TQ: Thu Quach, PhD

TN: Tung Nguyen, MD

JW: 00:00	Thanks for tuning in to another episode of the Clinical Problem Solvers Antiracism in Medicine series. This episode is in response to anti-Asian violence throughout the COVID-19 pandemic and the rise and fall of its discussion in the media. Consequently, this episode contains themes of violence, trauma-induced mental health concerns, and brief mentions of suicide. Please feel free to pause this episode and take a break if you'd like. If you or someone you know is struggling with suicidal thoughts, please call the National Suicide Prevention Hotline at 800-273-8255. That's 800-273-TALK. [music]
JW: 00:51	Welcome back to another episode of the Antiracism in Medicine series of the Clinical Problem Solvers podcast. As always, our goal in this podcast is to equip our listeners at all levels of training with the consciousness and tools to practice antiracism in their health professions careers. Today's episode is titled Centering Asian Americans: Racism, Violence, and Health. I'm joined by two of our incredible team members, Rohan Khazanchi and Jenny Tsai. Rohan, could you please tell our listeners our intention behind this episode? And Jenny, will you be able to introduce our guests?
RK: 01:26	Yes. Thank you, Jazzmin. So, so excited for this conversation. Our series to date has focused really heavily on equipping our listeners with a thousand-foot toolkit to understand structural racism. But as we try to reimagine a more just and equitable healthcare system in this series, we have to hone in on how white supremacy operates in different ways to place specific minoritized groups at the margins too. The movement for health equity and antiracism should leave no stone unturned, which is why this episode, like our last episode on anti-Indigenous racism, will be targeted at how a particular minoritized community is impacted by interpersonal, cultural, and structural racism. So I'll pass the mic to Jenny to introduce our guests.
JT: 02:06	Thanks so much. With that framing in mind, I'm really excited to introduce and tell you a little bit about the guests on this episode. Dr. Thu Quach is the incoming president at Asian Health Services, which is a federally qualified health center in Alameda County, serving approximately 50,000 patients in English and 14 Asian languages. As

an epidemiologist, she has used her public health background to anchor a number of key initiatives, including starting up the specialty mental health department, galvanizing national partners in the One Nation movement to fight the anti-immigrant policies and promoting patient engagement and empowerment. If that's not enough, Dr. Quach, during the pandemic, has been leading AHS in addressing racial disparities in COVID-19. She is also part of the co-founding board of the Progressive Vietnamese American Organization PIVOT, which politically engages and empowers Vietnamese Americans for a just and diverse America.

JT: 03:00 Our next guest, Dr. Tung Nguyen, is a professor of medicine at the University of California, San Francisco, and director of the Asian American Research Center on Health, which has over 40 individual and organizational members dedicated to improving the health of Asian Americans. He's a nationally renowned researcher who has conducted numerous groundbreaking community-based health research focusing on health disparities for the Asian American population. And again, if that wasn't enough, he's also served as a commissioner on President Barack Obama's Advisory Commission on Asian Americans and Pacific Islanders. He is the founder and also currently serves as the president of PIVOT.

JW: 03:38 Thanks for that, Jenny. So these are both incredible bios, and we're really, really excited to have these experts share their perspectives with you all. So first, Thu, tell us a little bit more about you and how your lived experience as an Asian American has played into the health, equity, and antiracism work that you've done in the public health and health policy arenas?

TQ: 04:00 Thank you. Thanks so much for having me. It's a great opportunity to share some of the experiences I've had and how it's shaped my journey into the work that I do today at Asian Health Services. So I was born in Vietnam right around the end of the war in 1975. Because my dad had actually been involved in the war and was trained by the US CIA, we had to get out of the country. He had an opportunity to leave at the fall of Saigon, but because he couldn't take us along, his whole family, his wife and three kids, young kids at the time, he decided to stay behind. And so we actually left the country in 1978 on a small boat and got to the refugee camps and lived there. And then I came to the US a little bit before I turned five. And I would say that our resettlement journey in the US was just as difficult as leaving Vietnam. My parents, both of them, came with nothing and three young kids, and we relied on public assistance, whether it's food, whether it's housing, Medicaid. And I served, along with my siblings, served as the child interpreter for them in many areas, including in healthcare, and many times, when I was at the hospital at seven, eight, bringing my homework along to interpret for my mom, who may be experiencing some health issue. And so much of that had shaped why I was really so into working in the healthcare field, but in a way that addresses the many issues faced by immigrant and refugee communities.

TQ: 05:39 And so I went to UC Berkeley and stumbled upon Asian Health Services, and actually volunteered as what's called a labor coach. So I

was able to accompany Vietnamese women into the delivery room and helped deliver two babies. And most of the time, I served as an interpreter, but also as just a cultural broker, bringing them hot water and being able to explain why their husband didn't want to go into the delivery room because of some of the traditional ways. But it wasn't, I would say until I had gone on and gotten my public health degree and actually came out, and my mom, who was a long-time hair and nail salon worker, was diagnosed with cancer that I really, really understood what it meant to really be a marginalized community. So many of the workers in nail salons are Vietnamese, limited English proficient, and it was actually her diagnosis and then her passing a year later that really drove me to do research in that area, and working with Dr. Tung Nguyen on many of the groundbreaking research that really looked into why Vietnamese workers were exposed, what they were exposed to with the chemicals that they were working on, and really using that research to impact policies and also to engage workers to have a role in their health. And then slowly, that brought me to Asian Health Services, which I can share a little bit more about later.

JW: 07:10 Thank you so much for sharing all of that with us. And I'm sorry about your mother's experience and her passing, and it's incredible what you were able to do with that experience and allow that to do work that could help save many other women's lives. And so, Tung, we'd also love to hear similar from you about how your lived experiences have played into your health equity work, and in particular, we would be really fascinated to learn more about your time with the Obama administration.

TN: 07:42 Sure. My early story is kind of a variation on Thu's story. So a little bit older, 11, when we left Vietnam as refugees. Had a lot of family separation along the way. But then our family of four, my parents and me and my brother ended up in Harrisburg, Pennsylvania, which is kind of a weird place for someone from a tropical country to land. We kind of missed a lot of cultural things, particularly food. But really, while we were growing up there, same experience with Thu of really brokering my parents' lives in the United States. They were the one doing menial job to make money, and we were the ones, me in particular, brokering the relationship with the English-speaking world, and had the experience, like Thu, of translating for my mom, who, besides the usual health stuff, was suffering severely from depression and PTSD, well, the refugee experience. And so that made that experience of cultural brokering and interpreting pretty difficult for a teenage boy. And really, out of all of that-- I've thought about this a little bit recently, and that experience, that one single experience of being in the clinical room with my mom and a doctor and sort of brokering that made me realize that's exactly how I ended up doing the kind of work that I do, which is on the one hand, I wanted to be the person to help the individual patient get better. And on the other hand, I wanted to be the person to break the system that forced us into that situation where the individual patient couldn't get better without a lot of external assistance. So that's how

I ended up going to medical school because I wanted to do the individual helping side.

TN: 09:22

And then eventually became a researcher and then became a policy person because I wanted to address a structural, systematic side. And I would say the main thing that's driven my work is both sort of a curiosity and a need to always follow the data where it goes. I think a lot of us sort of restrict ourselves to the things that we think we know how to do. I don't restrict myself that way. If I'm a genuine scientist that I think I am, if the data says this is where the problem is, I need to go there to fix that problem. And whether that's, oh, there's not enough data on Asian Americans, we have to collect more data, that's what we go to do. If there's no interventions with Asian Americans, we're going to go and create some interventions and collect some data. If there's not enough community engagement, we have to go out and do that. And then, at the end of the day, it's the policy, lack of healthcare access, things like that are the ones that are keeping people from being healthy, then we need to engage in that process. And whether that process includes generating policy, generating data, or advocating for legislation, that's what we do.

TN: 10:23

And that's sort of how I ended up working for the Obama administration was I got to the point in my career where I tried taking care of patients. I tried writing research papers. And what I realized was at the end of the day, those things were helpful, but they were still constrained very much by legislation and policies and government actions. And serving on the Obama administration, number one, allowed me to have some input into how some of that work gets done, but also a better understanding of how that gets done, and so I can take it back to my day job of being a doctor and being a researcher.

RK: 10:59

I really appreciate both of you sharing both your personal stories and kind of the professional journey that came after. And I think so much of your experiences are universal among children of immigrants or immigrant families, these stories of being cultural brokers or navigating the healthcare system for a family member with limited English proficiency. Many of us come to medicine because we want to do this work at an individual level, and I also appreciate so much how both of you talked about how even those individual interactions or experiences you had yourselves inform the way that you approach problems structurally and you recognize that even though as individuals, many of us are drawn to that interpersonal part of medicine, the structural is really where the bigger impacts can happen. And that's why both of you took a step back and did some of that bigger picture work as well.

TN: 11:49

Yeah, I've been teaching a lot of medical students. I mean, they ask me to come talk about why I do what I do. And one of the things that I try to emphasize is that being a clinician is really hard because you're expected to take care of a patient, and both of you are doing your very best, and you still can't get the outcomes you want because of the structural constraint. But what happens when you're a clinician just focusing on the individual patient, it's very easy to get

into a situation of frustration, and you end up blaming the nearest person, which is the patient. [laughter] And it's a typical burnout situation for clinicians. And I think this is not just for me helping them. It's for me helping me. For me to survive as a clinician, I have to have an outlet when I see structural problems that I can try to fix that instead of trying to just focus on an individual solution to structural problems, which never work, right? So that's why I think all clinicians should at least entertain the thought of what is it I'm doing inside the examining room or the hospital? And what is it I can do outside of it that actually addresses the very same issues?

RK: 12:55

Yeah, that's so important. And that's a theme that I think every single one of our podcast guests has talked about. I'm thinking in particular about when we spoke with Dr. Camara Jones, and she said that biomedicine's narrow focus on the individual is the root cause of so many problems, right? It's that we think that the individual level of intervention is where clinical work stops when in reality, medicine gives us this lens into the structural, right? It gives us this lens that we can use to inform how we intervene at the policy level, how we speak to policymakers about the challenges that we're facing or our patients are facing. So totally, totally agree. I think that's been a recurring theme in our conversations.

TN: 13:33

Well, I'm not going to go against Dr. Camara Jones. [laughter] I love her. But coming from an Asian society, growing up there and then coming to the United States, which is classically an individualistic-driven society, and living in a Asian society that's very communal-driven, there is a tension between individual and communal value, as we are seeing now with things like the COVID vaccine and things like that. I think you have to be careful in both ways. You have to be very-- I think because we live in the United States, we have to focus more on the communal and the structural issues. But you also have to be very careful because you can also live in societies where the lack of individual focus also hurts. So you have to be very careful.

RK: 14:12

So, Thu, I'd love to direct a question your way, and I think this is really a conversation that was the impetus for us starting the process of developing this episode, which is just what has been happening in Asian communities around the country during the COVID-19 pandemic? By now, we're all aware that there's been a dramatic uptick in discrimination and harassment and violence, including heinous assaults against elders in our communities. And in fact, California shared data that showed that there has been a 107% increase in reported anti-Asian hate incidents during the pandemic, which are levels that lead the nation. And I know this has been deeply personal for both of you, as many of these horrific attacks have occurred in the San Francisco Bay Area. And as we were talking about preparing for today's episode, Jazzmin and Jenny and I were reflecting upon how it seems like so many of these conversations were transient in the national spotlight. They came and went so quickly in public discourse. And now we see almost no conversations in the media about anti-Asian hate. So, Thu, I just wonder, from your personal experiences working with the Asian Health Services. Can

you just share a little bit with our listeners about what you've seen the physical and mental health impact of these incidents, and why you think these discussions were so short-lived?

TQ: 15:27

Yeah, so I'll back up a little and just describe to you what Asian Health Services is. We're a federally qualified health center. But our origin story is that it was started by UC Berkeley students who grew up in Oakland Chinatown and saw that their own communities couldn't get healthcare, mainly because of language and because there was no cultural competency. And so we have committed ourselves to the role of not just service but advocacy. And so we have a long history. It's in our DNA, not just to provide service. Earlier, you talked about the clinicians. Our clinicians are expected to be advocates, not just at the individual level but at the systems level. And so we've always taken that approach. And in so many ways, we have brought together a team of 500 incredible individuals: doctors, nurses, community healthcare workers, all around. I would say that we have been serving since 1974 about 50,000 patients in English and in 14 languages, and many of our staff come from the very communities that we serve. And so that's an important piece in all of this.

TQ: 16:35

I'd say when COVID hit-- we have to remember that the fault lines on disparities have already existed. And what it did was it really just exasperated everything that was happening. And as a community health center, we also see ourselves as an advocacy hub for so much of what's happening in the community. I can tell you that early on in the pandemic, it's like we had walked out in Chinatown, and Oakland just was empty. We'd never seen it before. Chinatown shouldn't be empty, right? And yet, it was empty. And we knew that patients could-- and I would say that because we were really connected with countries like China and stuff, we kind of got some inkling of this virus a little bit earlier on, and we were already asking patients to come in and wear masks and asked about travel history, and just taking all the precautions. But then, when shelter in place hit California, everything went empty, but it was a different type of empty. And we knew something was wrong, and our own providers said, "Hey, I'm getting calls that patients are committing suicide. They're crying out." Our mental health professionals were saying, "This is awful. I've never seen this happen before." Yet when it came to the narrative, everyone kept saying, "Hey, this is impacting Black and Brown communities," and it really was. But it was also impacting the Asian community, and we were completely missing from that narrative. And it just again reinforced this concept of the model minority myth. But the other narrative was that we were the cause of the virus. So here we are both simultaneously blamed for the virus but ignored when it came to services that we needed.

TQ: 18:22

I remember it was June, and I said we've got to find out. We can keep telling these stories, but no one's listening to us. And so I set out, and I told my CEO, "I got to do something." And she said, "Do whatever. Everyone, just do everything you can," because it was just unprecedented times. So I gathered our staff and said just call them and do this survey. And so we conducted the survey. We were

hoping we'd get a few hundred within a month. We got 1,300 responses, mostly from Chinese immigrants and Vietnamese immigrants. And we found that only 3% of them were getting tested. It was so different from what the county rates were. And we know that testing was kind of hard in the beginning. And there was a sense that when we asked this question like, "Are you leaving your homes for things like grocery stores?" 73% of them were saying no, and they were reporting things like depression, anxiety. And I didn't have time to go get IRB when you're thinking about research, but we knew this was it. It just confirmed what we were seeing and hearing. And we took it to the county and said, "You cannot ignore us. You cannot ignore our community." I was sitting on the COVID Racial Disparities Task Force put in by the city and county. And after a while, they started funding us to do our own COVID testing. And so we opened up our first sites in August. And it was the fact that we could actually do high-volume testing. But the signaling of us in the parks was a signal to our community that you can come out now. It was important for them to see the frontline workers out and about. And that created a change. We started seeing the community starting to come out because we were providing in-language support, but because we were signaling to them, it's okay, we'll be here.

TQ: 20:05

I would say that the other hard thing was that I would get calls from my own staff saying one of our staff was attacked or patients have been attacked. These things were happening in the beginning of the pandemic. It was early on in terms of the anti-Asian violence. Patients were saying they get on the bus and they're told to sit in the back of the bus. They're being spat on and yelled at for wearing your mask, things that they're supposed to be doing. All of this we were hearing, and we started talking to health centers across the nation, and all of this was true. We knew this was happening. All the staff were experiencing it where they were trying to hide from all of this, and staff were reporting they were afraid to even come into work. That has not totally gone away, I want to say. That fear still exists. And so we had to place our own community ambassadors out to protect the staff, to be out on the ground. But so much of this was about how do you use service as a form of advocacy, right? Being out and about, providing the care, the signaling to our community that we are there for them. And then using data that we were collecting to tell the county, to tell local officials, to tell the state, you cannot ignore this population.

TQ: 21:19

I also want to give a major shout-out to Tung because early on, we as researchers in this field knew that we had to do something, and the data wasn't completely there. And so he organized researchers, and we were meeting weekly, I think, for months and months just saying where's the data and how do you get the data to really shape the narrative that we are impacted in multiple ways? Not just on the COVID front but also on the anti-Asian hate. So overall, I think what's happening on the ground is that we can't rely just on the data. And even when they do exist and we do the analysis, I think there is this form of racism that just shuts us out and makes us invisible. And by being invisible in many of the discussions, we either become the

model minority myth, or we become the cause of the problem. And we can get more into what that all means when it comes to racism, but I wanted to share with you that on the ground, it wasn't new, but it wasn't because we were silent either. There was a system working against us.

TN: 22:25

Yeah, I wanted to chime in on that. There's different kinds of racism, right? There is the racism that actually catches people's eyes, the pushing down of the elder, or the shooting in Atlanta, the shouting and screaming at people. And certainly, those are all horrific, horrific things. They do catch attention, and as you say, they soon pass from our attention. And this is micro insidious racism of erasure, which is-- I mean, each minority group in this country has its own burden to bear when it comes to racism historically and currently. One of the biggest burden that the Asians bear is the racism of erasure, and erasure comes in different forms. Invisibility, people don't pay attention, they don't collect data on us, and then people pretend that we don't have problems. And so we don't even get to the point of saying we have a problem because they're like, you don't have a problem, whereas other groups are saying that we have a problem and everyone's yeah, you have a problem, but how do we go about solving those problems, right? We don't even get to that point. And to Thu's point, I mean, it's really hard to sit and watch your people suffer. And when the National Academy of Medicine and the CDC and a bunch of other sort of major health organization issue statements, like Thu said, very valid statements about other minority groups, but don't say anything about us, the implication being that we don't have a problem, right? All we wanted was for them to honestly admit what the truth was, which is we don't have good data on Asian Americans. And that in itself is an acknowledgment of a flaw in the system that we would have appreciated. But instead, by not listing us at all, they lumped us in as a non-problematic group. And I think that's why--

TN: 24:09

And I was very proud of our medical students at UCSF because they were the first ones to identify this problem. And they were the ones that pushed me to say, let's look at the death rates in San Francisco, and why is it that the Asian American death rates were so much higher than-- for COVID was so much higher than other populations? And out of that, we were able to work with other people, including Thu and a bunch of other teams across the country, to show that this was the case across multiple places. And eventually, eventually, when they actually used data that actually didn't miss Asian Americans, they showed that Asian Americans were under-tested, overdiagnosed, ended up in the hospital more, and died more when they were in the hospital compared to White people. And it took eight months for us to get to that point, during which time resources were not being sent to the community. So that's the kind of anti-Asian racism I worry about all the time. I mean, the other ones, they get to all of us, and we don't want that to happen. But this kind of insidious anti-Asian racism affects all Asian Americans all the time, like every minute of every day. So we want to pay attention to both those kinds.

TQ: 25:17

And I do want to add that as the nation started becoming more aware of the anti-Asian violence that was happening, there was a lot of gaslighting also that was happening to our community. Sort of like, "Well, it's not as bad as other groups." And as soon as you get into that zero-sum game, there's no winning, right, because you end up fighting amongst ourselves, right? And really, racism comes in different forms for different people, and it can't become compared, you know? And yet, so much of us trying to raise this was met with, "Well, it's bad, but it's not that bad." And I go back with my father-in-law, who recently passed, was a Japanese internee in Manzanar. And how do you tell someone, "Hey, your experience is not as bad as this?" I think that that is a danger in the conversations that are happening when we start trying to compare our oppressions. And it's not meant for that. And it's really important that we change that narrative so that we don't get into the zero-sum game because it's really the scarcity thinking that if tension is focused on this one group, it's taken away from another group. When really we're like, there is just consistent oppression that you put on each group, and we're going to fight this system so that it no longer does it to any of the groups, too. And we're going to unite rather than divide among ourselves to have that fight against structural racism.

TN: 26:52

If I can come in on that, Thu. Yesterday, we went to a talk. I don't know if, Thu, if you were at the same talk, but somebody put up a slide from Fred Hampton, the Black Power, Black Panther person from Chicago. And the quote was, "You don't fight fire with fire. You fight fire with water. You don't fight racism with more racism. You fight racism with solidarity and partnership and coalition building." And I have to say, it's hard enough to fight White people who are racist. I don't want to be fighting other people of color. That's not a win-- that's a no-win situation. So I'm always going to be highlighting the problems that other groups face and, at the same time, highlighting the problem that Asians face. And when we highlight the Asian problem, it's not because we're trying to denigrate or lower the expectations or the issue that other populations face. As a matter of fact, when we do that, we play right into the political strategy. It's an explicit political strategy, though, we have acknowledged.

TN: 27:51

Let's go back to the root of the model minority myth, right? So the root of the model minority myth is that in the 1960s, that the civil rights movement was rising, and the Asians were joining the Latinx and Black and Indigenous people. The Conservatives decided to look at how they can split that movement. And they decided to split that movement by focusing on Asians because they said, "Well, Asians are doing great. Obviously, it ain't a racial thing because if it's a racial thing, then why are Asians doing great?" That's a very specious argument that they came up with. And the funny thing, the ironic thing that Thu brought up her father-in-law, and the people they were looking at were Japanese Americans in the 1960s who were doing well as a group. And they conveniently ignored the fact that 25 years before that, they threw them all in concentration camps as if

that didn't exist. And the problem, though, is that everybody bought into that narrative. The White people bought into that narrative, the Black people bought into that narrative, Latinx people bought-- and the Asians bought into that narrative. And so out of that, it worked. They split us. And even to this day, you still have Asian Americans who don't understand the value of standing in solidarity with other civil rights groups-- other minority groups. But also, you also see other minority groups excluding us and attacking us, so on and so forth. Not everyone, but just generically speaking, that happens. And all that does is play into more racism against everyone.

TN: 29:18

So I just want to make sure that's very clear that whenever someone says what about this minority group versus the other minority group, you have to step back and say, "Well, who's gaining from this fight? Who's winning from this fight happening?" And it ain't the two minority groups that's going to gain. It's somebody else who's gaining. And the thing about politics and electoral politics, the progressive and liberal sides have been waiting for the social demographic change to occur, right? If the country goes a majority-minority, then the idea was that Black and Latinx and Asians were going to vote in a certain way, right? It's not going to happen because of the splitting. And politically, that is a strategy to split the Civil Rights Coalition.

TQ: 30:03

I'm just going to add on to that because I think the other thing we're struggling with-- so a couple of things. I think as Asian Americans, it's really hard to have to work so hard to convince people that you have issues and then try to have some energy to actually address those issues, right? It's exhausting. And yet, the first piece of it takes so much out of us. At the same time, conceptually and principally, it's true. There is structural racism, and people say white supremacy and all that. All of that is true. But yet on the ground, I think it's the head and heart. And so as we think about this, and as we figure out ways to talk to our community, I have to say we really suck at it. We suck. We tell our community, "No, you shouldn't feel mad. It's white supremacy." That goes over the head of an elderly Chinese person who's just been attacked, right? And so part of this is how do you take that and be able to listen and then try to figure out how do we engage so that we all move past this point?

TQ: 31:17

And so what I've been observing, and for Asian Health Services, we recently have been identified by different groups like the Asian American Foundation as the action center around anti-Asian hate. But we've committed to three areas. The first one is something I had wanted to do, and we're studying on, which is called a community healing unit. It's a place where we could actually help victims and their families, but also recognizing the community has been triggered by all of this and needs mental health support and also case management. But the second piece is around the importance of Asian and Black solidarity and recognizing that there is tension there. Let's not kid around. We need to figure that out. But we also need to figure out amongst ourselves before we can have those conversations, those harder conversations with each other. And if there's a conception like, hey, we're being divided, and it's white

supremacy, yeah. But how do you operationalize it in a way that's going to make sense and that people will actually want to engage? And it's really hard. It's really hard because there's a lot of baggage on all sides involved.

TQ: 32:31

And the last piece that we've committed to doing is really around this issue of changing the narrative, changing the narrative with the media. Changing the narrative with the mainstream. It's how do we talk about these issues that shifts the focus a little bit more than just victim and the perpetrators? Because those are easy to identify in one case. But if you look at a larger system, how do you talk about it? How do you engage ethnic media so they're not perpetuating things? How do you work with mental health professionals so that it's not just mental health care, but there's a toolkit around racism and such that we're providing clinicians and such. And all of that's really hard, and we are really scared about all the things that we promised that we're going to do. But I think the emphasis here is there's so many intellectual folks talking about this and less people doing it on the ground. And I want to emphasize that. And this work is really hard, and it's triggering for all of us that's involved, and it's emotional. And yet we still have to do it. And what I always say is we've got to stop talking about it as if it's this-- using terms like-- even though I believe there's white supremacy, when I say that to our patients, they shut down, right? They don't feel heard. And so part of it is how do we engage in a way that people feel heard and seen before we push our agenda on them too?

JT: 33:58

You guys are one, amazing, but I think you're making me reflect and think and get kind of emotional. I mean, for one, my dad had a really, really tough time during COVID, and this is a Taiwanese military man who told me he wasn't sure he was going to survive. He didn't know if he was going to survive this. He wasn't willing to leave the house. He felt like people were looking at him in a way, or he wasn't sure if he wasn't supposed to wear his mask, but then felt so unprotected. He told me, "I don't know what these people will do to me." This is also my dad, who, when I was a Brown undergrad student, I switched from a science major to ethnic studies, and the way that I got away with it is because I kind of muttered it under my breath. So for two years, my dad thought that I was studying ethics and bioethics because I knew he wouldn't be okay with me studying ethnic studies. And all through college, all through undergrad, it created a lot of difficulty. We got in a lot of arguments. We both felt like we didn't understand each other because I was gaining color consciousness. I was using phrases like white supremacy and wanting him to understand me. And he came from a very different background where he was very much like, maybe some things are unequal. What do you do? You be the best person that you can be, and you can't rely on other people, like very bootstraps. I'm like, "No, Dad, you've been corrupted. Come with me on this journey of color consciousness." So you're saying so much that feels really resonant and feels really true and also feels really personal.

JT: 35:41

Something that you guys have mentioned is this issue of racism as erasure, but also the more prominent media portrayals. I think there

have been many groups and your advocacy as well that's been ringing the alarms about not only the rise of anti-Asian racism in the pandemic but also the real inequities that exist outside of that. But I felt in a strange way that after there was this peak of media coverage about particularly visible violent crimes, including the six Asian American women who were murdered in an attack in the Atlanta area, one thing that I really thought about was how uncomfortable it was that suddenly Asian American scholars were so much more relevant and so much more sought after to comment. Again, in my career and my experience, it seemed like, as Tung said, there is a racism of erasure. All through my career, I was told that Asian Americans didn't really face inequities. They were doing okay or at least more okay again with this issue of the minority myth. Can you talk a little bit about how the systemic harm towards Asian populations can grow and actually perpetuate itself more when it's under the radar? And also, how we make sure that examples of violence are not just transient? How do we maintain energy and attention even when these more prominent and violent media events aren't happening?

TN: 37:10

I want to answer that, but I want to actually not gloss over what you really started out talking about, which is this intergenerational stuff. Again, I mean, those of us who are children or grandchildren of immigrants understand intergenerational dynamics drive a lot of our personal relationship, but they also drive a lot of the political relationship. One of the things that we grasped when we were working together in PIVOT during the 2020 election was the disconnect between older Vietnamese immigrants and refugees and their younger children. I mean, this whole conversation about Trumpism was like-- a lot of them were just-- a lot of the young people were just complaining about how hard it was for them to talk to their parents and grandparents about politics because there was this huge disconnect. And the bottom line is that everybody has trauma, different kinds of trauma, and acknowledging those trauma is where we connect. I think coming back to Thu's point at how do we connect on an individual personal level so that we're not talking about-- even though politics and structure is what drives the interaction and the problems, the solution has to be in connecting interpersonally, and for Asian Americans internally, at least, intergenerationally, with stories, storytelling, and really revealing each of ourselves to the other as being genuine human beings and where we find commonalities. And we think that's where the solution is. I guess maybe I'm being Pollyanna-ish, but eventually, that is where the solution is that we all see each other for who we are and engage each other on the human level.

TN: 38:50

But as far as sort of thinking about how do we stay out of this sort of erasure problem. We are not going to wait for other people to do it for us. We're going to stand up. I don't know what the myth of the quiet Asian person is. I don't actually see any quiet Asian people anywhere I go. And I've seen quiet Asian people in Asia. They're all very loud. And so I don't understand that. Why is it that we're perceived not to be politically active? Many of us are not politically

active. But I think, in the arts world, in the media world, we know a lot of people who are working in many different levels to elevate the visibility of both who we are and what our issues are. And that's the way to get to that is to continue to do that. And we hope to have allies in this process. Allies who are White, allies who are Black, supporting us just as we are supporting them.

TQ: 39:45

Maybe on the intergenerational piece, I think that's an important one that we want to really focus in on. So for me, I think a lot of my work is often grounded in what I call the lived experiences, whether it's my own or that I see among our patients in our community. And it was interesting because when all the protests were happening that was related to the Black Lives Matter, during a pandemic, we saw again, our community get really scared. And it's interesting on our board we actually are required as a federally qualified health center to have a majority patient consumer board. And I would hear from the older patients and the younger patients. And it was interesting because so much of it was about wanting racial equity, and then also recognizing that the older generation don't understand that, and actually only see protests, and it was actually triggering their own experiences in their homeland. And so there was this note that we were given from one of our elderly patients who shared with one of our board members saying that she doesn't understand. All she sees is violence, and she's scared, just like what had happened in China. And she said, "I don't know what to do." And you hear so much in her.

TQ: 41:17

And so it makes me think that people are having conversations with different contexts. And that's what I see on the ground still is that we're talking at each other. There is the younger generation saying, "We have to do this," and the older generation saying, "I have to protect you. We have to run again," right? And it's actually really heartbreaking because we are seeing love within a family carried out in different ways. And it's really hard because our mental health professionals were saying there is so much intergenerational trauma that's going on in the household from all of this pandemic. People are brought together, they have different views, and they've never learned to really talk to each other. And it's now coming out. It is full-blown. And so much that we are dealing with parenting classes and figuring out how to get generations to talk to each other. But on the flip side, I was sharing that the other amazing thing I got to see as we set up the vaccination clinics was watching the younger generation bring the elderly to get vaccinated. And I get to witness them crying as they watch their elderly parent and grandparents get the shot that could save their life because, in the beginning, it was mostly the elderly that were eligible.

TQ: 42:44

And so how do we take all of this? How do we take the love for each other and the conflict and be able to live through it and make it work? And so to what you were saying, Jenny, I really see so much opportunity as we talk about how do we work across the generations, right, and not just live through it. And as someone who's-- both parents are gone, I really look at all this and really think, wow, there is so much there that I wish I could have those fights and

debates with my parents on the political side. And it's only when it's gone that you really are thinking back on what you could say. And so I see that this is a time in our community where we aren't just dealing with the racism from the outside. We are dealing with so much more. It's like this reckoning. It's not just a racial reckoning. It's a generational reckoning. And it's really about how do we create space to actually push through this? And so I get scared, but I also get excited about the opportunities that are in front of us.

RK: 43:56

I really like this theme of intergenerational strength. I think that's maybe what I would call it, that I'm hearing from Thu and Tung both. And it reminds me of-- you mentioned this kind of vignette of younger generations bringing in their grandparents to get vaccinated. It might surprise some of our listeners, but Nebraska is no different than the rest of the country in seeing inequities impacting Asian Americans because we have huge Hmong and Vietnamese and Nepali communities, primarily refugee communities that came over to the United States recently or even a decade, two decades ago that have struggled during the pandemic. They're working-class communities and have seen enormous disproportionate impacts. And I remember, first of all, in one of my lectures having a student ask, "Oh, why are Asians overrepresented in the COVID cases in Nebraska? I don't know anything about these communities. We haven't talked about them at all in our medical school." Again, that erasure of communities in my backyard where we should be learning.

RK: 44:55

But then seeing that community strength as well, right? There's a group of high school students at a local high school, Benson, that actually emailed a faculty member. So imagine you're a public school student. Your family is new to the United States, and you went out of your way, and you emailed a doctor that you saw on TV, one of my mentors, Jasmine Marcelin, and they said, "We want to do something because we know that the elders in our community want to get vaccinated. But the vaccination is not coming to them, and the information's not coming to them in a way that they can understand it. But we, as a group of high school students, think we can help bridge that gap." And so even for me in my backyard, knowing that these communities were there, this was a moment of cultural strength, right, where again, high school kids were leading us and telling us, "We know exactly how to navigate this conversation because this is our family, this is our grandparents, this is our parents." And they were dragging their family members to the vaccination clinic that we ended up setting up in their neighborhood. And that was just a beautiful moment. In academics, we talk about strengths-based or asset-based versus deficit-based framing. And I think that was a moment where I saw the assets in our Asian American community.

RK: 46:01

But I want to come back to a point that Tung made earlier about the data erasure and how health disparities facing Asian Americans are often just a story left untold because we don't even have the data. So just for our listeners to really understand this in full, I wonder if one or both of you can highlight the concept of data disaggregation

as it relates to Asian American health disparities and why this is just so critical to advancing health equity for our communities?

TN: 46:30

Yeah, I can get started. Although it actually ties into your story from Nebraska, by the way, which actually makes it working with Asian Americans really hard because we know that most of them are some generation of immigrant one, two, three, fourth generation, and they come over for 30 to 40 different countries. They speak over 100 different home country languages. So that's disaggregation right there. And yet, when you start thinking about Asian Americans who live in San Francisco versus Nebraska versus Georgia versus Iowa, that's a whole different other set of disaggregation, right? So it gets to be pretty tough. I mean, even as an Asian American researcher, I'm like, jeez, I can barely figure out the Chinese in San Francisco. What do you want me to do about the Burmese in wherever it is you're talking about? I don't know. I mean, so it could be pretty daunting from that point of view.

TN: 47:20

But I'll start back on the data problem by saying we don't even have good Asian American data. Forget about the disaggregation. We're still struggling with all kinds of stuff with Asian American data. When we were asking for data on COVID, we would have been happy just to get good Asian American data from each of the 50 states, and we couldn't get that. There was a lot of "others" in the data reporting, like, who are these others? There are probably a bunch of Asians in there, you know? And so let's not be-- the perfect [inaudible] good. I would just settle for good Asian American data. Okay, so we'll start with that. But then, in sort of slightly more enlightened places like California, where they do try to look at more disaggregated data, even there, it's pretty limited, right? Some data collection is not in Asian languages. So, for example, if you do a surveys study of Asian Americans and it's in English and Chinese, you're still missing a bunch of people, right? Much less most national health survey data, for example, is English only or English and Spanish, which capture a few Asian Americans. But there's at least a third to almost a half of Asian Americans who are missed. So you get data back about Asian Americans that are completely wrong, completely non-representative.

TN: 48:35

So that's a first-- the other thing I want people to understand is whenever you read something about Asian Americans, number one, they're not collecting it well. Number two, it's not representative in any way, shape, or form, generally speaking. And then, of course, if you care about Chinese or Indian or Pakistani or Thai or Burmese, there's almost nothing really good out there for any of this stuff. And that speaks to the lack of investment, and that goes back to allocation of resources. My argument has always been that, on average, Asian Americans do well economically. We have bimodal distribution and so on and so forth. But because on average we do well, we think that we contribute to the tax base equally as any other population. Yet, investment and data collection and research on Asian Americans is horrible. I mean, the paper that we've been citing is that over the last 30 years of NIH funding, not even 1%, 0.12% of the funding was allocated to Asian American work when we

are 6% of the population and presumably 6% of the tax base. So you can sort of understand how there's so little known about any of our population because there's been significant underinvestment.

TQ: 49:44

I can add maybe two specific examples that really show disaggregated data, and data in itself is power. I think earlier, I'd shared about the survey we collected. So during COVID, we actually opened up some of the testing sites and were able to get a lot of people tested. And we work with the county, and all of a sudden, one of the bills that had been passed by then Assembly member Rob Bonta, which is requiring data disaggregation came through. And so we were able to collect those who were getting tested at our site, their racial, ethnic identity, but it's now disaggregated. And we started looking at the data we were getting back. And when you aggregate the Asian Americans and who was getting positive, it was about 2% or something, right? Not as high. But when we disaggregated, we saw that Vietnamese around that time was among the highest. It was like 6%, and at times even higher, right? So then we took that data, and we actually honed in into the area of like Oakland, Little Saigon kind of area there, and we did major outreach and really encouraged them to go and get tested. That was a prime example that we highlighted. So this is where disaggregated data cannot just be waiting for some researcher. It is immediate. It is beneficial. And it actually saves tons of money, right?

TQ: 51:11

And then the other thing that we also saw, which really enrages Asian Health Services and many others who were telling the story, was when the vaccinations started happening, everyone was scrambling. We had set up for vaccination overnight, and yet there was so much need, more than any of us could handle, and then we were trying to get the vaccines in. And for our patients, we were able to provide them with that in-language service, and then we were slowly kind of building ourselves up for the community. But we started hearing stories where people couldn't access. They would go on to the website, and it wasn't in language. They say, "Oh, call this number. It has all the languages," and our staff called it, and it was only available in English and in Spanish. If you look at vaccination, it's never just you go and you get vaccinated. It's never that simple. You have to find an appointment. You have to make an appointment. You actually have to get there. You have to be screened to make sure that you haven't had other vaccines before that, that you don't have certain reactions. And then afterwards, you have to be explaining what side effects we have. At every single point, we saw barriers that they were not providing language access.

TQ: 52:19

Now, remember during a PIVOT call with Tung and all those, I'm like we should take the motto of Stop AAPI Hate and start a website where we can capture these incidents where they have failed when it came to language. And keeping in mind that under Title VI, language access for federally assisted, federally funded programs is a civil right. This is required. So we started collecting that. And as soon as the government heard us collecting it, they were like, "Oh, that's really interesting. Let me look into it." But this is where we didn't even have to have the data. You just have to say that you're

collecting it, and it is really going to get attention. And I think, for all of us, as you get into thinking about research, and data in a publication, sometimes just getting it and also the threat of getting data to highlight the problem is power in itself. And it is an example of where sometimes you can't wait for the government to do it. You just got to go out there and do it, and then force them to collect it systematically, too. And so this is where I always talk about the power of community, not even just organizing, but people on the ground, hearing the stuff and making the changes immediately. And in those examples, we were able to make changes right away. And now, we ensure that things are translated. We ensure that there are interpretation. And it was really interesting because we got into the San Francisco Chronicle, and I was making these problems up. And I think the government, California, was like, "No, that's not true. If you call in, it's available in all the languages." And the reporter called and said, "Yep, it's only available in English and in Spanish," right? It is pushing them and not taking their word for it because the lives that are impacted are our own community, and if we don't raise it, no one's going to do it.

TQ: 54:12

And so I think it gets to the third point that I want to make is that it is about encouraging those within our own community to really be in a place where we can represent, where we will lift up the issues that other people coming in won't see. And I always highlight that. I say it's not about hoping that someone believes in some concept and wants equity. It is ensuring it is our own up there fighting for our own people because many times, issues you bring up are going to be the ones that other people won't see. And I keep saying this theme like our lived experiences and those of our family and our community is what should be guiding us, whether it's in research, whether it's in practice, in any of those things, because that's really what we have to do. We have to lift up the voices of our own community.

TN: 55:06

I want to respond to that with two things. One is sort of-- Thu and I are really tired. And the reason why we're really tired is every time we see a problem, no one else wants to fix it except people like us. The government doesn't want to fix it. She just gave you an example. Oh, how are we going to deal with people not getting access to the vaccine? Oh, we have to start our own website. And the same thing we did with COVID information in Vietnamese. Who got the information out there in Vietnamese? Nobody. So we had to create our own website. That's, in a way, that's what Thu is saying, that we have to take care of ourselves. But I think that's the immediate solution. That's what we have to do. But I don't think that's the right solution for a country that everybody who suffers both the problem and the lack of resources has to come up with their own resources to deal with the problem. That's one of those deadly cycles of structural racism. That's just not the way to do it. I mean, we have to do it because our people are suffering, and if we don't do it, they suffer even more. But we cannot be the only ones dealing with this problem. So that's the first thing I want to say.

TN: 56:14

The second thing I want to say because this is a podcast that's going out to a lot of clinicians is that there's inherent structural racism against all groups, but particularly among Asian in the way that we run our clinical environment. And go back to the vaccine example. So the way that UCSF, my hospital, rolled out the whole vaccine thing back in late last year was, oh, we're going to send out MyChart messages to the patient portal, to all the patients about how to do it, okay? Simple, makes lots of sense. What they forgot to think about was about 50 to 60 percent of the patients were on portals, but the other half were not. And of those who were not, probably predominantly more likely to be minorities and non-English speakers. Why? Because the portals can't really be used very well. And you can imagine. If anyone has ever tried to send a MyChart or a patient portal message in Chinese, you understand how hard it is to even do it, much less to access it or read it. So what happened was I had-- most of my patients are Asians. A couple of months later, I knew without even looking that most of my patients would not have been vaccinated because the whole strategy of reaching them to get the vaccine is based on a digital technology that's inherently built to be biased against people who don't speak English, people who are older, people who are minorities, okay?

TN: 57:32

So there are these daily sort of reminders if you're an Asian patient in the healthcare system that the system doesn't care about you. If you call in, you may not get to speak with someone who speaks your own language, right? I have this terrible experience with some of my patients who live in Chinatown, and I work a bit farther away. They rather get on the bus, come to my office, talk to one of my office assistants in their language for a little problem. They didn't make the phone call or send the MyChart message, which really is the reverse of what convenience is, right? So everybody who practices in a healthcare setting needs to look at everything that you're doing and sort of take a step back and say if you happen to have a family member who doesn't speak English, how are they navigating this? And what are the fundamental assumptions that's being made about how they're navigating this that is making their healthcare worse and making them aware of the racism underlying all of this?

JW: 58:28

Thank you so much, both of you, for sharing both of those things. I think one point that I just wanted to just kind of reflect on is I love how for the both of you, you don't really see your careers as limited into one bucket. And so when you see a problem on the ground, you not only collect the data, but you also take that data even further and try to design interventions to solve that problem at a local level and then see how you can push that at state and federal levels as well. I think that's so important for anyone in healthcare. And so to see two people really embody that work and say how, hey, this is all actually interconnected. And if we are really in the business of taking care of people and prioritizing their health, we can't ignore any of these buckets. And I really appreciate how you, Tung, in your last remarks, were trying to tie this into the clinical realm. That's definitely one thing that we like to do on our podcast after we have these discussions is we like to ask our guests to provide one key

takeaway for our listeners who are heading back into the clinical world tomorrow. What's one thing that they can put into practice tomorrow? And so the two of you want to just sort of comment on that question, and Tung, if there's something else that comes to mind that you want to share for our clinicians, we would really appreciate your advice.

TN: 59:58

I think it's all about seeing the eye through someone else's-- seeing the world through someone else's eyes. And one of the exercises we did years ago when we were trying to figure out how a patient walking around UCSF was, we asked someone to pretend they didn't speak English and try to get to an appointment. [laughter] And it was a very interesting exercise. It was eye-opening about how hard it is, that we make certain assumptions about what people's capabilities are. And that's the only-- I mean, I think a clinician-- maybe I'm a little too idealistic, but the goal about being a clinician is to take care of the patient the way they want to be taken care of, right? So how are you going to take care of somebody the way they want to be taken care of if you don't know where they're coming from and what they're seeing and what they're facing? The whole point about asking all these questions in their history is to elucidate what it is that they're experiencing, right? But it's not just about the medical symptoms, it's about-- let's call it the societal symptoms that they're dealing with. What are you seeing? Do we ever ask the patient?

TN: 01:01:01

My patients show up late for clinics all the time, and I used to be-- when I was young, I usually got really upset, like, "You're late. You're late. You're making me late." And then I realized they've taken three buses to come and see me. They can't find parking because it costs 15 bucks. I'm like, if I don't understand that, of course, my clinical encounter is going to be more difficult, right, because I don't have any sympathy for what they're going through. And whether it's Asian or not Asian, I think you have to understand that. And then to ask yourself those questions and diagnose those problems and solve them the way you would for hypertension. If your patients don't take a blood pressure pill, you don't say, "Well, you're noncompliant," and forget about it. You're like, "Why are you not taking it?" Well, some of that has to do with how hard it is to go get a prescription filled. I mean, my patients don't even know what a refill is. My Asian patients don't know what a refill is. They're like, "I'm out of the-- I don't have any more medication." And I say, "Look at the zero or the one or the two on the refill." So, oh, okay. But the instructions aren't necessarily in their language, right? But these inherent racist things are happening all the time in the clinical setting. If you're just paying attention, you'll get there. And I just want you to at least ask the question, if your mother and father were like this person who couldn't speak English or whatever, how would they negotiate the system that I'm in, and what can I do to either ameliorate those problems or behind the scene fix those problems so they don't have to deal with it on a day-to-day basis?

TQ: 01:02:29

I let Tung go first again because I should say I'm not a clinician, but I work with the providers as well as the staff and where we are at as a community health center. I would say that community health

centers, in so many ways, were designed in a way that recognizes that it is the social determinants of health that actually impact the patients greatly, whether it's their income, their language barriers, their immigration status. And so, in so many ways, we have shaped ourselves so that we can look into those issues other than just diagnosing the problem. And so I think as clinicians, it is treating what is at hand, but seeing the patterns across different communities. And so, for example, our wonderful providers and staff know that when they're seeing a refugee patient from Burma that it is more than just whatever they're complaining about with some of the trauma that they've been through and recognizing that. Or during fearful times for immigrants because either ICE is there or there was the fear of public charge which penalize them. You have to look beyond just what they're sharing with you, but also the context in which they're coming to you, right? And I think that as clinicians, it is hearing, but also taking in the environmental factors, the political landscape, so much that's going on and being able to raise those issues so that they get addressed or actually being part of the movement that's going to address those things too.

TQ: 01:04:16

And so I would say, again, I'm not a clinician. I don't pretend to be one. But I would imagine that some of the stuff that you hear from patients is not uncommon and that there's some consistent pattern. And what we always do share with our providers is tell us about it because sometimes it feeds into something greater and bigger that we could actually address as an organization and that it's not just upon you. And I think it is also creating space so those things can be shared. And I'll give you the example. I was involved because of my mom and the work around the nail salons. But Asian Health Services got involved because when it was being raised to some of the doctors, they were saying, "Actually, many more Vietnamese patients are coming in complaining about difficulty in breathing. They have these skin irritations, and they happen to all be nail salon workers. So you're right." But if you're not creating space to have these conversations, people are just treating it on an individual basis. So I think it does speak to really seeing the whole person and also the factors that affect a community and a group of people and not just that one isolated situation.

TN: 01:05:27

I want to turn slightly positive for a second because I was kind of a little negative. But for a clinician, this is not an additional burden. This is the additional benefit. This is the additional benefit. This is what's sustaining. It's like for me, having been a clinician for many, many, many decades, I would say that yes, I'm happy when their blood pressure is under control, but I'm much happier when I understand where my patient's coming from. I'm much happier. And over time, those relationships are really deep. And if you just try to understand the societal problems that your patients are facing and empathize and at least try to do something, you'll build relationships that are so much more meaningful than just a transaction of, "Oh, here you are. I'm writing your prescription, writing you a lab order," and things like that, so.

JT: 01:06:20

Thank you guys so much for this incredible episode. I mean, I'm thinking about so many things. One I think a major takeaway is I need to go call my parents. Thanks, mom and dad. I don't think you'll ever hear this, but thank you so much. We've spoken so much, and I mean, right when we started, right when I joined, Rohan and I talked extensively about how we felt being on this podcast, what it meant for two people who weren't black to be on leadership on an antiracism podcast, and how we could be mindful of that. And it's something that we continue to talk about, something that we want to continue to be mindful of. But I think also selfishly and personally, I'm so glad that we've done this episode, and it reminds us that there is so much work to do. It's all hands on deck, and we have to be mindful of everything, just as Tung said. It makes me think of Andrea Smith's essay on the Three Pillars of White Supremacy and how if we focus too much on the Oppression Olympics, as you've kind of talked about, we end up holding white supremacy up stronger. And I'm also thinking about the slogan of Black Power, Yellow Peril. This idea of these foreign invaders, the solidarity in people of color, and what it would do. The idea of peril being danger, being a peril to society as it stands. And kind of the idea is like, damn right; you should be scared. There is peril for these structures that are so unkind, that are so devastating, that are so unequal when we can come together. So thank you both so, so much for spending your time with us, for giving us all your generous insight. It really means so much. [music]