Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Mitigating Asian American Bias and Xenophobia in Response to the Coronavirus Pandemic: How You Can Be an Upstander

Christopher P. Ho, MD, Alice Chong, MD, MHCI, Anand Narayan, MD, PhD, Erin A. Cooke, MD, Francis Deng, MD, Vikas Agarwal, MD, Carolynn M. DeBenedectis, MD*, Lori A. Deitte, MD*, Ann K. Jay, MD*, Nolan J. Kagetsu, MD*

INTRODUCTION

Imagine finishing a long shift in the operating room performing aerosolizing procedures on high-risk patients with coronavirus disease 2019 (COVID-19). You are walking home, and the next thing you know, a stranger confronts you on the sidewalk shouting, "Why are you Chinese people killing everyone? What is wrong with you? Why the [expletive] are you killing us?" This is exactly what happened to an Asian American anesthesia resident in Boston recently [1]. These incidents are unfortunately becoming more frequent and should not go unnoticed nor without a safe and appropriate response.

The COVID-19 outbreak began in Wuhan, China, in December 2019. News outlets initially referred to the novel coronavirus (provisionally designated 2019-nCoV) as the "Wuhan virus" or "Chinese virus" on the basis of its geographic origin. On February 11, 2020, the World Health Organization announced the new official terminology: severe acute respiratory syndrome coronavirus-2 for the virus and COVID-19 for the corresponding disease [2]. The terms follow World Health Organization guidelines on naming of new human infectious diseases, which should "minimize unnecessary negative impact of disease names on trade, travel, tourism, or animal welfare and avoid causing offense to any cultural, social, national, regional, professional, or ethnic groups" [2].

As late as mid-March, world leaders continued to use the term "China virus" or "Chinese virus." One could argue that the use of these terms is a microaggression, specifically as a verbal slight that enacts the stigma of contagion on another group of people. The impact of this kind of attitude has been felt within the United States and worldwide, as evidenced by a significant increase in anti-Chinese and anti-Asian sentiment. The Chinese government has requested that countries desist in using the term "China virus," citing harmful effects on diplomatic efforts.

Xenophobia against Asian Americans dates back to the 19th century with the 1882 Chinese Exclusion Act, the first immigration law that excluded an entire ethnic group. World War II ushered in the internment of Japanese Americans into camps under Executive Order 9066. In the United States, there is a history of ethnic groups, including Asians and Asian Americans, facing discrimination and prohibition on immigration, on the basis of claims that these groups bring disease into the country. This sentiment has fluctuated over time, often in response to times of societal hardship or unrest, but the recent and rapid uptick in xenophobic behaviors ranging from microaggressions to overt aggressive and threatening behavior is concerning. On March 19, 2020, in response to the rise in these behaviors, the Asian Pacific Policy & Planning Council developed an incident report form allowing Asian Americans to report episodes of hate. In its first 2 weeks alone, the council received more than 1,100 incident reports of "verbal harassment, shunning, and physical assault" in the United States [3]. With this increase in anti-Asian racism in the community, we in the medical field are seeing this sentiment extend to our health care personnel and must protect against its happening to our patients.

MICROAGGRESSION, XENOPHOBIA, AND RACISM IN THE HEALTH CARE WORKPLACE

A microaggression is a comment or an action that subtly and often unconsciously or unintentionally

1546-1440/20/$36.00 ■ https://doi.org/10.1016/j.jacr.2020.09.030

expresses a prejudiced attitude toward a member of a marginalized group, such as a racial minority [4]. Anti-Asian microaggression in radiology and medicine can be subtle, but it still exists today. For example, a physician might ask a new Asian American patient who presents with a cough, "Where are you from?" instead of asking for a travel or an exposure history. Or a physician might even assume that a patient needs a medical interpreter on the basis of their name. These are microaggressions because of the insensitivity to interethnic and intraethnic differences. Microaggressions are subtle and subconscious, but we as physicians need to be aware of how these statements and actions can have a large impact on the target and the culture of an organization [5]. This is critical because a large majority of people of color already distrust medical institutions. To provide care for those who are potentially the most vulnerable, we as health care professionals need to be able to address these issues and show support in the moment.

Although some health care workers face the stress of coronavirus exposure, lack of protective personal equipment, or isolation from family and friends, Asian American health care workers face the potential additional stresses of xenophobic behavior at and outside their workplaces. For example, consider the story of Dr Lucy Li, from our introduction. This is unfortunately only one example of what is happening to Asian Americans and our Asian American health care colleagues across the country. Stories of racial slurs, threats of violence and physical assault being thrown at our Asian American health care workers, should not be tolerated at any health care facility. All of our health care staff members deserve the right to feel safe and protected in their workplaces. We should be united in the fight against COVID-19, rather than letting it divide us.

RESPONDING TO AN INCIDENT

As a Target

How can we approach these difficult situations? When you are the target of a microaggression or an aggressive behavior, first consider both the context and your own safety. If you choose to respond, be sure to call out and discuss the specific behavior, not the aggressor themselves. Be aware that microaggressions can make targets feel as if they do not belong, so connecting with a social support system is key to processing the event. Recognizing our positions as physician leaders, we can cultivate an environment of belonging and awareness.

As a Bystander/Upstander

What if you are a bystander observing a microaggression or overt aggressive behavior happening to a friend, a colleague, or even a complete stranger? What actions can you take to mitigate this behavior? How can you move from being a passive bystander, who just observes an incident, to an upstander, a person who intervenes or acts in support of an individual who is being attacked or bullied? How can we move to become active allies, supporting or intervening in support of these marginalized groups, even if we are not part of those groups? Bystander interventions have been proved to work; they may produce uncomfortable situations, but they are effective and have real positive downstream consequences for both individuals and society in terms of fostering inclusion and promoting equality. There are groups that even offer training in these interventions. For instance, the organization Hollaback! provides simple and effective instruction on bystander interventions with their approach of the "5 D's": distract, delegate, document, delay, and direct [6]. Multiple additional techniques can be used to combat microaggressions (see Table 1). With training and awareness, we can help our patients

Table 1. Different techniques and frameworks to address microaggression

GRIT	Gather
	Restate
	Inquire
	Talk it out
Open The Front Door	**O**bserve
	Think
	Feel
	Desire
ACTION	**A**sk clarifying questions
	Come from curiosity and not judgement
	Tell what you observed in a factual manner
	Impact exploration: discuss what the impact of the statement was
	Own your own thoughts and feelings around the situation
	Next steps
XYZ	I feel **X** when you say **Y** because **Z**

and our colleagues in these difficult times.

Bystander/upstander interventions can help support not only Asian Americans facing xenophobia during COVID-19 but also other racial/ethnic groups and women who are targeted by harassment. Surveys from Penn State University and the University of Texas found that nearly 50% of female medical students reported sexual harassment during training [7]. Studies performed in a variety of settings have found that bystander training increases the likelihood that men and women will take action to reduce the impact of gender-based harassment. A study of 394 soldiers in the US Army found that soldiers who received in-person bystander intervention training reported that they were more likely to take action when they saw assault or harassment compared with soldiers who did not participate in this training [8]. Overall, these results suggest that bystander intervention training can help foster inclusive climates for women as well as racial/ethnic groups who may be targeted by abuse or harassment.

CONCLUSIONS

As xenophobia and racism are being exacerbated by the COVID-19 pandemic, having the awareness that this is happening to our Asian American patients and health care colleagues is essential in mitigating incidents and stopping the behavior. It is unacceptable that our frontline Asian American health care workers are being harassed, verbally and physically. As COVID-19 has spread across the globe, we should seize this as an opportunity to unite over a worldwide challenge rather than divide over long-standing racial attitudes. Making a commitment to implement departmental or institutional training sessions on microaggressions and upstander techniques for our health care providers and trainees is a minimum. These opportunities should extend to all marginalized groups regardless of ethnicity, gender, or sexual orientation. This important conversation must continue and be pervasive in our medical community so that we may protect and support our patients and health care providers.

REFERENCES

1. Corley J. Boston doctor becomes victim of COVID-19 racism. Here is how we should respond Available at: https://www.forbes.com/sites/jacquelyncorley/2020/04/14/boston-doctor-becomes-victim-of-covid-19-racism-here-is-how-we-should-respond/#679a5ceb3fa6. Accessed April 24, 2020.
2. World Health Organization. World Health Organization best practices for the naming of new human infectious diseases. Available at: https://apps.who.int/iris/bitstream/handle/10665/163636/WHO_HSE_FOS_15.1_eng.pdf. Accessed April 6, 2020.
3. Asian Pacific Policy & Planning Council. Stop AAPI hate. Available at: http://www.asianpacificpolicyandplanningcouncil.org/stop-aapi-hate/. Accessed April 4, 2020.
4. Microaggression. Available at: https://www.merriam-webster.com/dictionary/microagression. Accessed April 5, 2020.
5. DeBenedectis CM, Jay AK, Milburn J, Yee J, Kagetsu NJ. Microaggression in radiology. J Am Coll Radiol 2019;16:1218-9.
6. Hollaback! Guide to bystander intervention. Available at: https://www.ihollaback.org/guide-bystander-intervention/. Accessed April 9, 2020.
7. National Academies of Sciences, Engineering, and Medicine; Policy and Global Affairs; Committee on Women in Science, Engineering, and Medicine; Committee on the Impacts of Sexual Harassment in Academia; Benya FF, Widnall SE, Johnson PA, eds. Sexual harassment of women: climate, culture, and consequences in academic sciences, engineering, and medicine. Washington, District of Columbia: National Academies Press; 2018.
8. Potter SJ, Moynihan MM. Bringing in the bystander in-person prevention program to a U.S. military installation: results from a pilot study. Mil Med 2011;176:870-5.

Dr Ho, Associate Professor, Program Director Diagnostic Radiology, Department of Radiology and Imaging Sciences, Emory University, Atlanta, Georgia. Dr Chong, Associate Professor, Vice Chair of Clinical Operations, Residency Associate Program Director, Department of Radiology, University of California San Diego, La Jolla, California. Dr Narayan, Assistant Professor, Quality & Safety Officer, Division of Breast Imaging, Co-Chair, Diversity, Equity and Inclusion Committee, Department of Radiology, Massachusetts General Hospital, Boston, Massachusetts. Dr Cooke, Associate Professor, Department of Radiology, Vanderbilt University Medical Center, Nashville, Tennessee. Dr Deng, Resident, Department of Radiology, Massachusetts General Hospital, Clinical Fellow, Harvard Medical School, Boston, Massachusetts. Dr Agarwal, Associate Professor, Vice Chair of Education, Department of Radiology, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania. Dr DeBenedectis, Vice Chair for Education, Director, Radiology Residency Program and Associate Professor of Radiology, University of Massachusetts, Medical School, Worcester, Massachusetts. Dr Deitte, Vice Chair of Education, Department of Radiology, Vanderbilt University Medical Center, Nashville, Tennessee. Dr Jay, Associate Professor, Vice Chair of Education, Department of Radiology, Georgetown University Hospital, Washington District of Columbia. Dr Kagetsu, Associate Clinical Professor, Department of Diagnostic, Molecular and Interventional Radiology, Icahn School of Medicine, Mount Sinai Health System, New York.

The authors state that they have no conflict of interest related to the material discussed in this article. Drs Ho, Chong, Narayan, Cooke, Deng, Agarwal, DeBenedectis, Deitte, Jay, and Kagetsu are employees.

*On behalf of the Diversity Committee of the Association of Program Directors in Radiology.

Christopher P. Ho, MD: Department of Radiology and Imaging Sciences, Emory University, 1364 Clifton Road NE, Suite BG03, Atlanta, GA 30322; e-mail: christopher.ho@emory.edu.