cmajOPEN

Research

Discrimination experienced by Asian Canadian and Asian American health care workers during the COVID-19 pandemic: a qualitative study

Zhida Shang RN MSc, Jennifer Y. Kim PhD, Shuliang O. Cheng MBBS

Abstract

Background: Asian Canadians and Asian Americans face COVID-19–related discrimination. The objective of this qualitative study was to explore the experiences of Asian health care workers dealing with discrimination, with a focus on racial microagressions, in Canada and the United States during the COVID-19 pandemic.

Methods: We adopted a qualitative descriptive approach. We used convenience and snowball sampling strategies to recruit participants. We conducted individual, in-depth semistructured interviews with Asian health care workers in Canada and the US via videoconferencing between May and September 2020. Eligible participants had to self-identify as Asian and be currently employed as a health care worker with at least 1 year of full-time employment. We used an inductive thematic approach to analyze the data.

Results: Thirty participants were recruited. Fifteen (50%) were Canadians and 15 (50%) were Americans; there were 18 women (60%), 11 men (37%) and 1 nonbinary person. Most of the participants were aged 25–29 years (*n* = 16, 53%). More than half were nurses (*n* = 16, 53%); the other participants were attending physicians (*n* = 5), physiotherapists (*n* = 3), resident physicians (*n* = 2), a midwife, a paramedic, a pharmacist and a physician assistant. Two themes emerged from the data: a surge of racial microaggressions related to COVID-19 and a lack of institutional and public acknowledgement. Participants noted that they have experienced an increase in racial microaggressions during the COVID-19 pandemic. They have also experienced threats of violence and actual violence. The largely silent organizational response to the challenges being faced by people of Asian descent and the use of disparaging terms such as “China virus” in the early stages of the pandemic were a substantial source of frustration.

Interpretation: Asian health care workers have experienced challenges in dealing with racial microaggressions related to COVID-19 in the US and Canada. More research should be done on the experiences of Asian Americans and Asian Canadians, both during and after the pandemic, and supportive measures should be put in place to protect Asian health care workers.

The COVID-19 pandemic has had a devastating global impact. It has had dire socioeconomic consequences, including a massive strain on health care and social services worldwide[1,2] and a noticeable increase in the xenophobia experienced by Asian communities.[3,4]

Racism against Asian Canadians and Asian Americans is not a novel phenomenon. It dates back to the 19th century, exemplified by the term “yellow peril,” which was used to support legislated discrimination against people of Asian descent, regardless of nationality.[5] The *Chinese Exclusion Act* was the first law in the United States’ history to ban immigration of a particular ethnic group specifically.[6] This was followed in Canada with the *Chinese Immigration Act* of 1885. With the passing of the *Dominion Elections Act* in 1920, people of Asian descent were forbidden from voting in Canada until 1947.[7,8] Discrimination was not limited to people of Chinese descent, as Japanese Canadians and Japanese Americans were interned in camps during World War II.[9,10] Over time, discrimination against people of Asian descent has evolved into less overt racism in the form of racial microaggressions, defined as

Competing interests: None declared.

This article has been peer reviewed.

Correspondence to: Zhida Shang, zhida.shang@mail.mcgill.ca

***CMAJ Open* 2021 November 16. DOI:10.9778/cmajo.20210090**

© 2021 CMA Joule Inc. or its licensors

behaviour or comments that most often subtly demean and denigrate members of marginalized racial groups.[11,12]

The phenomenon of targeted discrimination during global pandemics has been seen throughout history; 1 example is the discrimination against people of African descent during the 2014 Ebola outbreak.[13] COVID-19 is viewed as an Asian virus because of the divisive rhetoric used by some media and political leaders, including former US President Donald Trump, who used the term "China virus."[14–16] Preexisting anti-Asian sentiment, buoyed by COVID-19's association with Asians, has culminated in numerous attacks, both verbal and physical, against Asian communities throughout North America,[3,13,17–20] including the Atlanta spa shooting in which 8 people were killed, 6 of whom were Asian women.[21]

Concerningly, these acts of discrimination may have carried over to the health care sector, where people of Asian descent represent a substantial proportion of the workforce; for example, 19.6% of US physicians and 8.4% of US nurses are Asian.[22] All health care workers are at high risk of experiencing negative psychological outcomes because of the nature of their work, but Asian health care workers are facing heightened racial discrimination in addition to the baseline stress of working on the hospital front line.[23,24]

We were interested in exploring the experiences of Asian health care workers during the COVID-19 pandemic. The research to date on COVID-19–related microaggressions has been limited primarily to commentary articles,[3,13,17] which have not analyzed the deeper, systemic complexity of xenophobia. Qualitative research may be well suited to the study of complex phenomena such as discrimination; it can enable researchers to better understand and explore the context of, and the meanings behind, the experiences of individuals. Our objective was to explore the experience of COVID-19–related discrimination, with a focus on racial microaggressions faced by Asian health care workers in North America.

Methods

Study design

We used a qualitative descriptive approach, which is appropriate for studies whose aim is a straightforward description of a phenomenon. Qualitative description allows for results to stay close to the data, giving a comprehensive summary of events in everyday terms.[25] We wished to create a broad geographic and demographic qualitative sample because of the novelty and widespread occurrence of the phenomenon in question. This study adheres to the consolidated criteria for reporting qualitative research (COREQ).[26]

Participants and sampling

To be eligible for the study, participants had to self-identify as Asian American or Asian Canadian, be currently employed in health care in North America and have at least 1 year of full-time work experience in this sector. For the purposes of this study, we restricted the term "health care worker" to medical professionals who are members of a governing body that oversees the activities of its members.

We used purposeful sampling, which emphasizes the bounding of the context where we would most likely derive key findings.[27] Convenience and snowball sampling strategies (May–June 2020) were used. We drew an initial convenience sample from 4 Asian health care groups and associations: Subtle Asian Healthcare, Subtle Asian Nursing, Subtle Asian Physical Therapists and the Chinese American Medical Society. The first 3 are Facebook groups; we contacted their members via Facebook Messenger. The Chinese American Medical Society is a national association, which sent out an email to its members with background information about the study and our contact information. We chose this initial sampling method because we needed a fast and easy way to recruit participants as we were evaluating a time-sensitive phenomenon. Participants provided referrals to other Asian health care workers who were interested in participating.

Data collection

Individual, semi-structured interviews were conducted in English between May and September 2020 via videoconferencing by Z.S. or J.Y.K. A semi-structured interview guide (Appendix 1, available at www.cmajopen.ca/content/9/4/E998/suppl/DC1) was created a priori by Z.S. and J.Y.K., which was informed by the microaggression literature[11,12,28] and refined as the interviews progressed. The interview guide was not pilot tested; however, many of the interview questions have been used in previous research exploring racial microaggressions.[28] The interview guide explores the experiences of discrimination, with a focus on microaggressions, other novel events, and perceptions of the lack of response of organizations and the media to both the challenges faced by health care workers and the specific hardships faced by Asian health care professionals.

Participants were given $15 Amazon gift cards upon completion of the interview. Prospective participants completed an online informed consent form, which included information about the purpose of the study.

Data analysis

Interviews were transcribed verbatim by Z.S. and J.Y.K. and subsequently analyzed using NVivo 12. We adopted an inductive[29] thematic approach for coding and analysis, allowing themes to emerge from the data,[30] which is useful when there are no previous studies on a phenomenon.[31] Z.S. (male, Chinese Canadian) and J.Y.K. (female, Korean American) have graduate-level training in qualitative methods and prior publications in qualitative research. Given the sensitive nature of racial microaggressions, we purposefully matched the race of the interviewers with that of the interviewees to promote disclosure and minimize discomfort.[32] Both Z.S. and J.Y.K. independently coded all transcripts; differences were resolved in consultation with S.O.C. (male, British Chinese). All 3 authors discussed the emerging themes related to the research questions and extant literature, using an iterative consultative approach that allowed for reflexivity and deep exploration into the themes.[33]

We undertook various measures to enhance the trustworthiness of the study.[34] To ensure credibility and confirmability, we used debriefing meetings and iterated between the emerging themes and existing literature.[35] Also, at the conclusion of each interview, we summarized the findings and asked the participant for feedback. Data collection was halted after thematic saturation[36] was achieved.

Ethics approval

Ethics approval for this study was granted by the Universidad de los Andes.

Results

Interviews, ranging from 37 to 68 minutes in length, were conducted with 30 participants, representing a diverse range of ethnicities, professions and medical specialties (Table 1). All potential participants who expressed interest in the study completed an interview. The sample comprised 15 (50%) Canadians and 15 (50%) Americans, including 18 women (60%), 11 men (37%) and 1 nonbinary person. There were 16 (53%) nurses, 5 (17%) attending physicians, 3 (10%) physiotherapists, 2 (7%) resident physicians, 1 midwife, 1 paramedic, 1 pharmacist and 1 physician assistant. Thematic saturation was achieved after 27 interviews, and we conducted 3 more to confirm saturation.

Two major themes emerged from the data: a surge of racial microaggressions related to COVID-19 and a lack of institutional and public acknowledgement. Illustrative quotes are presented in Table 2.

Surge of racial microaggressions related to COVID-19

Participants noticed a notable spike in manifestations of what we, as the author group, identified as racial microaggressions related to COVID-19. Although most participants shared that they had experienced racial microaggressions before COVID-19, they noted that the frequency and severity of the microaggressions have increased during the pandemic and attributed this complex phenomenon to their racial status. These microaggressions were enacted most frequently by members of the public, but many were also enacted by patients and their family members, colleagues and acquaintances. The following are some examples of the more subtle types of microaggressions that participants experienced: being glared at, being questioned constantly about common Asian stereotypes (e.g., being asked if wet markets in China sell bat meat), having their ethnic origin questioned (e.g., being asked if they were from Wuhan, China), and having their health (but not the health of their non-Asian colleagues) questioned (e.g., being asked if they had COVID-19).

Many participants also experienced more blatant and direct COVID-19–related microaggressions resembling old-fashioned racism, including direct avoidance (e.g., requests to be seen by a non-Asian doctor), derogatory racial stereotypes (e.g., accusations of eating bats or dogs), alienating statements (e.g., “go back to China”) and explicit racial profanities (e.g., “chink” or “gook”).

Six participants noted that they had experienced threats of violence linked to COVID-19, including threats of sexual assault or physical violence, or actual physical assault (i.e., being spat on by a patient). Four of those participants were women, and 5 out of 6 said that the incident happened while they were wearing scrubs in public near their workplace. Those who were threatened or assaulted noted that these incidents happened at a time when there were lax clothing regulations (i.e., change of clothing was not required on exiting health facilities). The 4 female participants noted that wearing scrubs in public contributed to the likelihood of experiencing racial and gender-based abuse. All 6 participants experienced a range of negative emotions and cognitive processes, including anger, fear, despair, rumination (reflecting upon the incident repeatedly) and hypervigilance (paying more attention to their surroundings and worrying about their safety).

The Canadian and American participants reported similar forms of COVID-19–related microaggressions. Although none believed that these interactions affected the quality of care they provided to the patient, participants shared a range of negative emotions, including anger, anxiety, frustration, annoyance, stress and feelings of isolation.

Lack of institutional and public acknowledgement

Nearly all participants expressed dissatisfaction with the handling of the pandemic by their institutions and their country’s leadership. Participants expressed ambivalence about being praised superficially as selfless heroes while receiving little support regarding the unique hardships they faced. A prominent example of politicization was the use of the terms “China virus” and “Kung flu” to describe COVID-19, a move that was universally condemned by Canadian and American participants of all ethnicities. Consequently, many remarked that even the superficial commendations from the public and workplace “went down the drain” for their failure to acknowledge the hardships faced by Asian health care workers experiencing microaggressions related to COVID-19. Most participants shared that their workplace did not issue any communication about the racial challenges faced by the Asian community at the peak of the pandemic, which enhanced their feelings of isolation and invisibility.

Participants expressed added frustration with their lack of agency in being able to challenge these racial tropes and terms, especially in the workplace. For example, when patients used derogatory terms to describe COVID-19, participants felt torn between maintaining their integrity and conserving the patient’s trust. In these situations, most participants chose not to correct the patients. The few who spoke up did so in a subtle but firm way, using correct terminology to describe the virus. Overall, participants expressed disappointment about the invisibility of Asian issues and attributed this racial and scientific ignorance to the systematic failure of the North American leadership at the time.

Table 1 (part 1 of 2): Sociodemographic characteristics of participants

Characteristic	No. (%) of participants n = 30
Gender	
Female	18 (60)
Male	11 (37)
Nonbinary	1 (3)
Nationality	
American	15 (50)
Canadian	15 (50)
Age, yr	
< 25	4 (13)
25–29	16 (53)
30–34	3 (10)
35–39	5 (17)
≥ 40	2 (7)
Ethnicity	
Chinese	8 (27)
Filipino, Filipina	5 (17)
Vietnamese	5 (17)
Taiwanese	3 (10)
Cambodian	2 (7)
Korean	2 (7)
Multiracial	2 (7)
Japanese	1 (3)
Malaysian	1 (3)
Pakistani	1 (3)
Worked with COVID-19 patients?	
Yes	22 (73)
No	8 (27)
Practice setting or specialty	
Medical–surgical	7 (23)
Intensive care	4 (13)
Adult outpatient	3 (10)
Internal medicine	3 (10)
Cardiothoracic surgery	2 (7)
Obstetrics and gynecology	2 (7)
Pediatrics	2 (7)
Anesthesiology	1 (3)
Emergency medicine	1 (3)
Family medicine	1 (3)
Infectious diseases	1 (3)
Neurosurgery	1 (3)
Palliative care	1 (3)
Rehabilitation	1 (3)

Table 1 (part 2 of 2): Sociodemographic characteristics of participants

Characteristic	No. (%) of participants n = 30
Profession	
Nurse	16 (53)
Attending physician	5 (17)
Physiotherapist	3 (10)
Resident physician	2 (7)
Midwife	1 (3)
Paramedic	1 (3)
Pharmacist	1 (3)
Physician assistant	1 (3)
Location	
Urban	28 (93)
Rural	2 (7)

Interpretation

Our findings show the challenges experienced by Asian health care workers during the COVID-19 pandemic in Canada and the US. Asian health care workers noted that they have experienced a relative uptick in racial microaggressions, in addition to threats of physical and sexual violence and actual physical assault, which they attributed to COVID-19. Furthermore, the largely silent organizational response on Asian issues and use of disparaging terms such as "China virus" were sources of frustration. Participants' frustration was particularly salient amid the growing politicization and racialization of the pandemic, evidenced by the increasingly negative portrayal of China and Asia in the media by political leaders such as former President Trump, which caused participants to feel self-conscious about their Asian identity.

Despite these challenges, the Asian health care workers who participated in our study said they provided excellent patient care, as they understood their crucial role in combating COVID-19, demonstrating a sense of professional integrity seen in other studies.[37–39] However, without adequate support, Asian health care workers are at greater risk for developing adverse psychological and physical outcomes.[23,38,40,41] Thus, it is critical to provide robust support to Asian health care workers, who are at risk of stressors associated with working in health care and anti-Asian racism. Supportive measures include raising organizational awareness about general anti-Asian discrimination and COVID-19–related microaggressions, implementing debriefing sessions[23] and offering professional psychological services.[42,43]

Our study highlighted the perception that non-Asian North Americans tend to ignore the distinctions among the various racial, ethnic and cultural backgrounds of members of the Asian community.[28,44,45] This is exhibited in our study by the fact that both Chinese and non-Chinese Asians

Table 2: Major themes and selected illustrative quotes

Theme	Illustrative quotes
Surge of racial microaggressions related to COVID-19	To protect myself and other shoppers, since I work in a COVID unit, I decided to put a mask and gloves on. But every time I go to grocery shopping, I get this specific look, that uncomfortable look from people. Once I even got told to go back to China. (RN 11, nurse, Canadian)
	A lot of people at the beginning were talking about how bad China is, how they will never eat Chinese food again … . Idiots … . Then people will ask my opinion on COVID and about the markets and bat eating, but I am Filipino! I honestly have no idea about China; I have never been to China! (PT 2, physiotherapist, American)
	I keep on hearing these random comments: "oh those chinks" or "oh those Chinese people." But I have to keep silent, since I still have to do my job, which is to give meds [to patients]. It is weird, since part of me wants to stand up and say: "I am Chinese; not all Chinese are carriers," but the bigger part of me just wants to get the day over with and give them medication. (RN 8, nurse, Canadian)
	This lady was in a particular room for a long time, a 4-bedroom patient room, and generally I would be assigned to all the patients in that room. This patient will talk to her neighbours saying, "Don't take anything from that nurse, she is contaminating everything with the COVID!" (RN 6, nurse, Canadian)
	She kept on screaming that I am provoking fear and that I am the reason for this confusion for society, and that I am COVID positive, since I have a mask on. Then she was questioning that if I was COVID positive, why am I even outside. She said I am from China, and that people like me have COVID and shouldn't be outside. (RN 3, nurse, Canadian)
	From that experience [verbal abuse while commuting to work and wearing scrubs], I have been too scared to go on the train anymore. I keep thinking back on it. I kept thinking back about her taking pictures of me, and her racist remarks, and I don't know why everyone's go-to word is "chink" or "ching chong" … I feel like it was more racially driven than health care driven, or it could have been a combination against both. (RN 3, nurse, Canadian)
Lack of institutional and public acknowledgement	They have signs everywhere saying that they are health care heroes, we get drawings from kids thanking us for what we do. But sometimes it feels like it is theatrics and acting rather than actual action. I have never heard of places giving hazard pay to nurses. It is worth being angry about, basically being a sacrificial lamb, and not protect yourself because you signed up to be a health care professional, and this is what you have to do. It's pretty disheartening for a lot of doctors and nurses. (MD 4, physician, American)
	I feel like America has failed its health care professionals. I don't want anyone calling anyone a hero. I do think that the nurses in ICU, doctors and cleaning staff are heroes and are all amazing, but they did not sign up to be a hero; they signed up for a job. I personally have a problem with that rhetoric, and they need to take away that hero talk and compensate people appropriately. (PT 1, physiotherapist, American)
	We need to narrow the gaps in communications between the higher-ups and hospital health care workers. A lot of the time, even our immediate managers were unaware of the plans happening at the higher level, and what has happened within this pandemic was that the health care system was reactive, not proactive. So the moment that the politicians said what was gonna happen, it was a top–down effect. (RN 10, nurse, American)
	It makes me angry that politicians makes these stupid comments, like Trump, about China or Chinese people. Then people will think that if Trump says it, then it is ok for me to say it too. And I think it plays such a big role in how people here think, like people here are protesting against wearing masks, which I don't think anywhere else in the world people are doing that. (MD 1, physician, American)
	This [COVID-19] is a political issue and it's rooted in racism and socioeconomics. Honestly, it feels like the French revolution right now, it's deeply rooted in so many things that are wrong with this country, I knew that something like this was going to happen. And it is seriously wild that Asians are being used as a punching bag for this. (PT 1, physiotherapist, American)

Note: ICU = intensive care unit.

believed that they were targeted. Although general discrimination against health care professionals is not new, the participants unanimously attributed these incidents to their ethnicity.[46,47] The very nature of these microaggressions made salient the participant's race, illustrating that these were racially motivated microaggressions and not generalized acts of aggression toward health care workers. COVID-19–related microaggressions are an evolution of the microaggressions that minorities have traditionally faced in the workplace[24,28] but that have become more prominent and centred around COVID-19.[44,48]

Limitations

Although the qualitative nature of our study provides a rich, nuanced portrait of the experience of Asian health care professionals contending with COVID-19–related microaggressions, future studies may wish to quantitatively assess the prevalence of microaggressions related to COVID-19 experienced by Asian health care workers and other minority groups. This study is limited to the interpersonal aspect of racial microaggressions. Future studies using a more specific qualitative methodology, such as a critical race or grounded theory approach, may better examine the systemic roots.

As for the sample, it consisted predominantly of nurses, who may be more likely to work regularly in close proximity with patients and thus may have more opportunities to experience microaggressions related to COVID-19. Furthermore, there may be response bias, where participants in our study may have been more interested in Asian issues or may have experienced more COVID-19–related microaggressions. A related limitation is that the experiences of support staff, such as unit coordinators, were not explored. Future studies may individually examine the experiences of different types of health care professionals and support staff. Lastly, it is unclear if the racial abuse was due partly to the participants' practice, where the acuity of some clinical situations may lead to patients, family members or colleagues inadvertently delivering COVID-19–related microaggressions. However, this reason is less likely given that our sample included a diverse representation of different medical practices and units. Importantly, participants felt that these racially insensitive interactions were targeted toward health care workers of Asian descent.

Conclusion

The Asian health care workers in our study described contending with the burden of COVID-19–related racial microaggressions and verbal and even physical violence. They felt that their experiences had been largely ignored and were struggling with challenging these racial tropes while maintaining their dedication to patient care. Considering this, we call on health care organizations to provide additional support to safeguard the well-being of Asian health care workers to ensure that they can continue providing quality care both during and in the aftermath of the COVID-19 pandemic.

References

1. Nicola M, Alsafi Z, Sohrabi C, et al. The socio-economic implications of the coronavirus and COVID-19 pandemic: a review. *Int J Surg* 2020;78:185-93.
2. Walker PGT, Whittaker C, Watson OJ, et al. The impact of COVID-19 and strategies for mitigation and suppression in low- and middle-income countries. *Science* 2020;369:413-22.
3. Tessler H, Choi M, Kao G. The anxiety of being Asian American: hate crimes and negative biases during the COVID-19 pandemic. *Am J Crim Justice* 2020 June 10 [Epub ahead of print]. doi: 10.1007/s12103-020-09541-5.
4. Gover AR, Harper SB, Langton L. Anti-Asian hate crime during the COVID-19 pandemic: exploring the reproduction of inequality. *Am J Crim Justice* 2020;45:647-67.
5. Yellow terror in all his glory. Columbus (OH): Origins: Current Events in Historical Perspective. Available: https://origins.osu.edu/article/image/yellow-terror-all-his-glory (accessed 2020 Aug. 8).
6. Huang J, Liu R. Xenophobia in America in the age of coronavirus and beyond. *J Vasc Interv Radiol* 2020;31:1187-8.
7. Abu-Laban Y, Nath N. Citizenship, multiculturalism, and immigration: mapping the complexities of inclusion and exclusion through intersectionality. In: Tremblay M, Everitt J, editors. *The Palgrave handbook of gender, sexuality, and Canadian politics*. Cham: Palgrave Macmillan; 2020:507-27.
8. *A history of the vote in Canada*. 3rd ed. Gatineau (QC): Elections Canada; 2021.
9. Irons P. *Justice at war: the story of the Japanese-American internment cases*. Berkeley (CA): University of California Press; 1993.
10. Sunahara AG. *The politics of racism: the uprooting of Japanese Canadians during the Second World War*. Burnaby (BC): Nikkei National Museum & Cultural Centre; 2020.
11. Kim JY-J, Block CJ, Nguyen D. What's visible is my race, what's invisible is my contribution: understanding the effects of race and color-blind racial attitudes on the perceived impact of microaggressions toward Asians in the workplace. *J Vocat Behav* 2019;113:75-87.
12. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol* 2007;62:271-86.
13. Cheng SO. Xenophobia due to the coronavirus outbreak: a letter to the editor in response to "The socio-economic implications of the coronavirus pandemic (COVID-19) – a review." *Int J Surg* 2020;79:13-4.
14. Coronavirus: Trump seems to undercut US spies on virus origins. *BBC* 2020 May 1. Available: www.bbc.co.uk/news/world-us-canada-52496098 (accessed 2020 Aug. 8).
15. President Trump calls coronavirus 'kung flu.' *BBC* 2020 June 24. Available: www.bbc.co.uk/news/av/world-us-canada-53173436 (accessed 2020 Aug. 8).
16. WHO issues best practices for naming new human infectious diseases [press release]. Geneva: World Health Organization; 2015 May 8. Available: www.who.int/news/item/08-05-2015-who-issues-best-practices-for-naming-new-human-infectious-diseases (accessed 2020 Aug. 8).
17. Chen HA, Trinh J, Yang GP. Anti-Asian sentiment in the United States: COVID-19 and history. *Am J Surg* 2020;220:556-7.
18. In six weeks, STOP AAPI HATE receives over 1700 incident reports of verbal harassment, shunning and physical assaults [press release]. San Francisco: Chinese for Affirmative Action; 2020 May 20. Available: https://caasf.org/press-release/in-six-weeks-stop-aapi-hate-receives-over-1700-incident-reports-of-verbal-harassment-shunning-and-physical-assaults/ (accessed 2020 Aug. 8).
19. STOP AAPI HATE National Report 3.19.20–8.5.20 [press release]. San Francisco: Chinese for Affirmative Action; 2020. Available: www.asianpacificpolicyandplanningcouncil.org/wp-content/uploads/STOP_AAPI_Hate_National_Report_3.19-8.5.2020.pdf (accessed 2020 Aug. 8).
20. Nicholson K. Surveys find more than 1,000 self-reported incidents of anti-Asian racism since start of pandemic: report: *CBC News* 2021 Mar. 23. Available: www.cbc.ca/news/canada/asian-racism-hate-canada-pandemic-1.5959788 (accessed 2021 Apr. 1).
21. Hawkins D, Craig T, Shavin M, et al. What we know about the victims of the Atlanta shootings. *Washington Post* 2021 Mar. 20. Available: www.washingtonpost.com/nation/2021/03/20/atlanta-shooting-victims/ (accessed 2021 Apr. 1).
22. Sex, race, and ethnic diversity of U.S. health occupations (2011–2015). Rockville (MD): US Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis; 2017.
23. Greenberg N, Docherty M, Gnanapragasam S, et al. Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ* 2020;368:m1211.
24. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. *JAMA Netw Open* 2018;1:e182723.
25. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000;23:334-40.
26. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349-57.
27. Patton MQ. *Qualitative research & evaluation methods: integrating theory and practice*. Thousand Oaks (CA): SAGE Publications; 2015.
28. Sue DW, Bucceri J, Lin AI, et al. Racial microaggressions and the Asian American experience. *Cultur Divers Ethnic Minor Psychol* 2007;13:72-81.
29. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval* 2006;27:237-46.
30. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77-101.
31. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nurs Health Sci* 2013;15:398-405.
32. Sue DW, Nadal KL, Capodilupo CM, et al. Racial microaggressions against Black Americans: implications for counseling. *J Couns Dev* 2008;86:330-8.
33. Riach K. Exploring participant-centred reflexivity in the research interview. *Sociology* 2009;43:356-70.
34. Lincoln YS, Guba EG. *Naturalistic inquiry*. Thousand Oaks (CA): SAGE Publications; 1985.
35. Gioia DA, Corley KG, Hamilton AL. Seeking qualitative rigor in inductive research: notes on the Gioia methodology. *Organ Res Methods* 2012;16:15-31.
36. Glaser BG, Strauss AL. *The discovery of grounded theory: strategies for qualitative research*. Piscataway (NJ): Aldine Transaction; 1967.
37. Liu Q, Luo D, Haase JE, et al. The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *Lancet Glob Health* 2020;8:e790-8.

38. Sun N, Wei L, Shi S, et al. A qualitative study on the psychological experience of caregivers of COVID-19 patients. *Am J Infect Control* 2020;48:592-8.
39. Verhoeven V, Tsakitzidis G, Philips H, et al. Impact of the COVID-19 pandemic on the core functions of primary care: Will the cure be worse than the disease? A qualitative interview study in Flemish GPs. *BMJ Open* 2020;10:e039674.
40. Spoorthy MS, Pratapa SK, Mahant S. Mental health problems faced by healthcare workers due to the COVID-19 pandemic: a review. *Asian J Psychiatr* 2020;51:102119.
41. Sheraton M, Deo N, Dutt T, et al. Psychological effects of the COVID 19 pandemic on healthcare workers globally: a systematic review. *Psychiatry Res* 2020;292:113360.
42. Chen Q, Liang M, Li Y, et al. Mental health care for medical staff in China during the COVID-19 outbreak. *Lancet Psychiatry* 2020;7:e15-6.
43. Rajkumar RP. COVID-19 and mental health: a review of the existing literature. *Asian J Psychiatr* 2020;52:102066.
44. Yu N, Pan S, Yang C-C, et al. Exploring the role of media sources on COVID-19–related discrimination experiences and concerns among Asian people in the United States: cross-sectional survey study. *J Med Internet Res* 2020;22:e21684.
45. Nadal KL, Wong Y, Sriken J, et al. Racial microaggressions and Asian Americans: an exploratory study on within-group differences and mental health. *Asian Am J Psychol* 2015;6:136-44.
46. Singh R, Subedi M. COVID-19 and stigma: social discrimination towards frontline healthcare providers and COVID-19 recovered patients in Nepal. *Asian J Psychiatr* 2020;53:102222.
47. Devakumar D, Shannon G, Bhopal SS, et al. Racism and discrimination in COVID-19 responses. *Lancet* 2020;395:1194.
48. Chiang PP. Anti-Asian racism, responses, and the impact on Asian Americans' lives: a social-ecological perspective. In: *COVID-19*. London (UK): Routledge; 2020:215-29.

Affiliations: Faculty of Medicine and Health Sciences (Shang), McGill University, Montréal, Que.; Center for the Study of Drug Development (Kim), Tufts University, Boston, Mass.; University College London Medical School (Cheng), London, UK.

Contributors: Zhida Shang and Jennifer Kim conceived and designed the study. Zhida Shang and Jennifer Kim recruited the participants and conducted the interviews. Zhida Shang and Jennifer Kim transcribed the interviews and coded the data. All authors contributed to the analysis and interpretation of data. Zhida Shang drafted the manuscript. Jennifer Kim and Shuliang Cheng revised the manuscript. All authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

Funding: Funding was provided by the Research Fund for Assistant Professors at Universidad de los Andes.

Content licence: This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY-NC-ND 4.0) licence, which permits use, distribution and reproduction in any medium, provided that the original publication is properly cited, the use is noncommercial (i.e., research or educational use), and no modifications or adaptations are made. See: https://creativecommons.org/licenses/by-nc-nd/4.0/

Data sharing: Owing to the sensitive nature of the topic of this study and the confidentiality agreement between the authors and the participants, research data from the study will not be publicly available.

Supplemental information: For reviewer comments and the original submission of this manuscript, please see www.cmajopen.ca/content/9/4/E998/suppl/DC1