

# **A JOINT STATEMENT FROM THE UCSF ASIAN AMERICAN AND PACIFIC ISLANDER COALITION TO THE UCSF CHANCELLOR AND PRESIDENT AND CEO OF UCSF HEALTH**

*AGAINST RACISM, XENOPHOBIA, BIGOTRY, MICROAGGRESSIONS, PREJUDICES AND  
OTHER DISCRIMINATING PRACTICES AFFECTING THE UCSF AAPI COMMUNITY*

May 28, 2021 (submission date)

Since the COVID-19 pandemic began in early 2020, a sharp rise in anti-Asian violence and hate speech has affected the Asian Americans and Pacific Islander (AAPI) community across the nation. Driven by the viral origin of COVID-19 pointing fingers at China, as well as long-standing discrimination and race tensions between Asians and other Americans, assaults, and killings of Asians in Chinatowns and across the nation, while not new, have become regular occurrences. In the March 2021 Atlanta shootings, a gunman drove to three separate Asian-owned spa and massage businesses and intentionally killed eight people, six of whom were Asian American women.

These unprovoked, targeted attacks on Asians fueled many AAPIs to reckon and re-examine the long-existing racism, xenophobia, bigotry, micro aggressions, prejudices, biases, the [bamboo ceiling](#) (a combination of individual, cultural, and organizational factors that impede Asian Americans' career progress inside organizations), scapegoating, and other discriminatory practices against AAPIS.

## **History of Asian Americans and Downstream Negative Impact**

Xenophobia, racism, and hate are sadly not new to the AAPI population. This nation has a history of racism against Asians including the [Chinese Exclusion Act](#) in 1882, the [Immigration Act of 1924](#), [Japanese American Internment in World War II](#), racial profiling of South Asians (especially those of Sikh or Islamic faiths) after September 11, 2001, and the recent weaponizing of the COVID pandemic against Chinese and other AAPI communities. As recently stated in [The New Yorker](#): “It is possible that being scapegoated might constitute one of the community’s few shared experiences.”

U.S. history is littered with deliberate acts of racism by the government as well as organizations. For AAPIS, this has been perpetuated through federal, state, and organizational laws and policies leading to the exclusion of AAPI, language and other forms of discrimination, limiting access to services and protections, and contributing to data scarcity and lack of disaggregated data for the Asian subgroups. Aggregated data masks the many health inequities and social injustices faced by different AAPI communities.

These discriminative structural practices, stemmed from the lack of understanding of the different AAPI cultures and the nature and scale of their problems, have resulted in othering AAPI and causing them to be seen as perpetual foreigners and the invisible minority.

## **The Anti-Asian Climate Today**

Systemic racism and invisibility allow institutions and individuals to “normalize” violence and hate crimes against Asian Americans. The recent escalation of assaults has stirred up intense per-

sonal anguish in the Asian American communities. Many AAPI experience racism but have not spoken up or are not heard, a challenge exacerbated by a cultural stereotype that Asians are tolerant, undisruptive, compliant, and passive. The part of the Asian culture to work for the collective good has been misinterpreted as weak, silent, and docile. By not ensuring our voices are heard, we collectively contribute to the invisibility of anti-Asian racism.

The “[model minority](#)” label has been used as a wedge to pit Asian Americans against other marginalized black, indigenous, people of color (BIPOC) communities, fueling anti-Black racism among Asian Americans and anti-Asian racism among African Americans. The model minority myth of universal success among Asian Americans also obscures the fact that many AAPI are struggling and face discrimination in the job market. Thus, there is no singular monolithic AAPI experience, and no model minorities. The model minority expectations have created pressures in the AAPI community and contributed to a high rate of mental health issues such as anxieties and depressions. According to the American Psychiatric Association, [suicide](#) was the 8th-leading cause of death for Asian-Americans while it was the 11th-leading cause of death for all racial groups combined.

Anti-Asian racism manifests in thinly-disguised, subtle biases and stereotypes that diminish our humanity and reinforce the bamboo ceiling. We are seen as capable of working hard, following directions to get the job done, but are viewed as incapable of having vision, judgement, creativity, emotional intelligence, and other traits required for organizational leadership. The presence of an Asian accent has often been erroneously equated with lack of competency or intelligence. These stereotypes cause many Asian Americans to get passed over for promotion and training for leadership roles. The current available UCSF workforce data shows a [drastic drop](#) of AAPI managers in M3 level and above, and few clinical department chairs in UCSF are AAPI, in step with other [study findings](#).

An important recent [report](#) by [LAAUNCH](#), the first report of its kind in 20 years, examines attitudes and stereotypes towards Asian Americans. This report found that nearly 80% of Asian Americans say they do not feel respected and are discriminated against in the U.S. This problem, however, is under-recognized by white Americans, 37% of whom are not aware of an increase in hate crimes and racism against Asian Americans over the past year and 24% indicating that anti-Asian American racism isn't a problem that should be addressed.

## **UCSF AAPI Coalition Recommendations**

The recommendations outlined below build on efforts of an earlier letter submitted to Chancellor Hawgood and President and CEO Laret by the Asian Faculty Leadership Group and the Asian Health Institute, as well as Asian Pacific American Systemwide Alliance's (APASA) communications with Vice Chancellor Navarro. Please refer to the Appendix below for more details on the proposed action plan.

- 1. Raise Awareness:** Increase the awareness and understanding of the AAPI history and culture, dispel AAPI-related myths, and to affect changes in the perception of AAPI. In addition, ensure adequate AAPI membership representation in the various UCSF institution-wide groups and initiatives.

2. **Collect and Disaggregate AAPI Data:** Improve data transparency and reporting by race on a regular basis, with the AAPI data further disaggregated for students/learners, employees, patients, and research participants.
3. **Strengthen Language Access for Patients and Staff:** Improve AAPI threshold language translation and interpreting around patient access, healthcare, research, and business practices.
4. **Break the Bamboo Ceiling for AAPI Faculty and Staff and Salary Equity:** Increase AAPI representation at the senior and executive level management positions across the institutions, along with training and support.
5. **Include AAPI when using the “URM” Term in DEI Initiatives and Communications:** UCSF has adopted an [outdated definition](#) from the original definition of Underrepresented in Medicine (URM) by the Association of American Medical Colleges (AAMC). But since the June 2003 Supreme Court’s decision on *Grutter v. Bollinger*, AAMC has broadened their [definition of URM](#) to mean “those racial and ethnic populations that are underrepresented in the medical profession *relative to their numbers in the general population.*” AAPI should not be excluded in the URM category given the [27% of UCSF AAPI faculty](#) in San Francisco with a [36%](#) AAPI population.
6. **Build Student Pipelines and School Admissions:** Recruit bilingual students to become interns to build pipelines of future bilingual healthcare workers to be in concordance with the language needs of the 35% AAPI in San Francisco (where half experience language barriers).

All actions count and matter. The above recommendations, detailed in the Appendix, will enable UCSF to embrace our principles of community and PRIDE values. To quote Dr. Renee Navarro from the recent Annual Chancellor’s Leadership Forum on Diversity and Inclusion, “We are not in a moment, we are in a movement.”

# # #

*We, the undersigned groups and individuals, endorse the Joint Statement above and respectfully request Chancellor Hawgood and Mr. Mark Laret to adopt the Action Plan in the Appendix:*

AHC – Asian Health Caucus  
 AHI – Asian Health Institute  
 APAMSA – Asian Pacific American Medical Student Association  
 APASA – Asian Pacific American Systemwide Alliance  
 UCSF AAPIC - Asian American & Pacific Islanders Coalition  
 UCSF Center for Child and Community Health  
 UCSF Center for Community Engagement  
 UCSF Committee on the Status of Women  
 UFA - Filipinx Steering Committee

*(Other groups and individual UCSF faculty, staff, and learners to be added below)*

**To Endorse this Statement: Click [SUBMIT](#)**

The Statement will be submitted along with all endorsements on 5/28)

# APPENDIX

## A Proposed Action Plan for AAPI in UCSF

The UCSF AAPI community includes our students/learners, staff, faculty, patients, researchers, and research participants. This is an *initial* proposed action plan intended to make a positive impact on the learning, clinical, research and working environment for AAPI, and to further advance the Diversity, Equity, and Inclusion (DEI) initiatives at UCSF.

### 1. Raise Awareness

Increase the awareness and understanding of the AAPI history and culture, to dispel AAPI-related myths, and to affect changes in the perception of AAPI individuals. Ensure inclusion of adequate representation of AAPI membership in the various UCSF groups and initiatives. AAPI has paid a minority tax through unequal treatment and are doubly punished through the neglect of recognition of their minority status. We recommend:

- a. Members of the Chancellor's Cabinet, the UCSF Office of Diversity and Outreach (ODO), and DEI groups to recognize in UCSF Health communications and in the quarterly DEI and other town halls, as well as any other venues deemed appropriate, the past neglects and discrimination that AAPI members experienced at UCSF which have inadvertently contributing to their invisibility
- b. Include AAPI in all DEI action plans as a corrective action. More specifically, include AAPI in the ODO-led Anti-Racism Initiative by meeting with AAPI leadership representatives quarterly to discuss the specific items/needs unique to the AAPI community
- c. Incorporate AAPI history and culture in the U.S. history and the UCSF history, as well as relevant AAPI details in the following trainings: [Foundational Diversity, Equity and Inclusion Training](#) and [Differences Matter Diversity, Equity, and Inclusion Champion Training](#) requirements for UCSF staff, faculty and students
- d. Include specific materials about AAPI in the Chancellor Cabinet's own ongoing education and training plan in anti-racism
- e. Include adequate representation of various AAPI leaders as speakers in town halls for the Anti-Racism Initiative
- f. Include adequate AAPI membership and representation in the following groups and others, and sanction work time for their participation:
  - UCSF DEI and Anti-Racism Initiative committees (<https://diversity.ucsf.edu/antiracism-initiative>)
  - All committees appointed by the Chancellor, or by members of Chancellor's Cabinet. e.g., Chancellor's Community Advisory Group
  - Safety Task Force
  - Patient Education Committee
  - Nursing leadership and Nursing DEI groups within UCSF Health
  - Any current and future leadership groups appointed by senior executive leaders

### 2. Collect and Disaggregate Data

Improve data transparency and reporting by race on a regular basis, with the AAPI data further disaggregated for students/learners, employees, patients, and research participants. Collect and disaggregate all AAPI data into Asian subgroups (Chinese, Filipino, South Asians, Vietnamese, Koreans, Japanese, other AAPI) for all patient data and reports, as well as the UCSF Staff Engagement Gallup Survey. We recommend:

- a. Patient safety data for inpatients by race
- b. Patient clinical outcome data by race for inpatients and outpatients respectively
- c. Patient's 30-day readmission data by race, preferred language, and principal diagnosis
- d. Patient data from patient discharge surveys by race
- e. Student's admission data from all schools by race and language proficiency
- f. Nursing Department data on RN staff and management levels by race and language proficiency

- g. Nursing data on RNs by race, language proficiency, and medical certified interpreter status
- h. Clinical providers (separated by credentials MD, PA, NP, PT, etc.) data by language proficiency and medically certified interpreter status
- i. Form a Data Oversight and Recommendation Committee to review the above data and make recommendations to improve patient care, access to care, care outcomes, as well as for institutional DEI

### 3. Strengthen Language Translation and Interpreting

Language discrimination is a form of racial discrimination. Additionally, language has significant implications around patient access, quality of care, health outcomes, research outcomes and business outcomes.

We recommend:

- a. Define and identify patients' threshold languages (threshold set at 5% of patient's preferred languages) specific to UCSF's inpatient and outpatient populations, similar to the process used by the City of San Francisco to identify and define threshold languages in its [Language Access Ordinance](#)
- b. Establish an organizational structure (separate from the Interpreter's Department) to provide oversight to the adoption of the Language Access Ordinance and to collect and summarize annual reports from each clinical department for the number of staff who can speak the threshold languages and their positions
- c. The Interpreter Department to submit an audit for review of its financial and staff data separated in accordance with UCSF's threshold languages
- d. Interpreter Department to share its fee structure and program of medical interpreters' certification and re-certification, as well as plan of identification and outreach to staff to invite qualified candidates to obtain medical interpreter certification
- e. Interpreter Department to provide a list of staff who are certified medical interpreters for each clinical department for the current year and thereafter annually for each threshold language identified for UCSF to the organizational structure described in 3b. above
- f. Patient Education Committee and all clinical Service Line Departments – Submit reports of the total numbers of patient education documents and the corresponding translated patient documents available in UCSF's threshold languages
- g. Incorporate language threshold requirements for all clinical departments as one of the IAP goals
- h. Improve access to care and quality of care for UCSF patients with limited English proficiency (LEP) by preferential hiring of at least one bilingual frontline contact staff who can speak each threshold language in various patient care and service areas
- i. Provide salary incentives for bilingual frontline contact staff who can speak one or more of UCSF's threshold language(s) with patients
- j. Use of the "Underrepresented in Medicine (URM)" in UCSF to incorporate the 5% threshold AAPI languages identified at UCSF as one of its criteria
- k. When the term "under-represented in medicine" is used, language congruence of healthcare providers needs to be added as one of the criteria to incorporate for evaluation
- l. Fund and Conduct marketing outreach in different media formats using the threshold AAPI languages
- m. Install multilingual signage that minimally includes Chinese and Spanish in all patient care areas and directional signs
- n. Install prominent QR codes/signs (in threshold languages) for instructions to make comments/complaints in patient care areas within each clinical department

### 4. Break the Bamboo Ceiling for AAPI Faculty and Staff and Salary Equity

[Forty-one percent](#) of UCSF employees self-identified as AAPI. However, that proportion of AAPI is not represented at the senior and executive management levels. Senior faculty leadership also lags behind the proportion of Asian faculty at UCSF in the schools and clinical departments. Furthermore, the [Economic Policy](#)

[Institute](#) found that AAPI women face a double pay penalty, and that on average AAPI women [earn 8% less](#) than their corresponding white male counterparts. We recommend:

- a. HR to develop an action plan to address diversification of faculty senior leadership positions and executive management levels to adequately include not just BIPOC, but also immigrants whose English is not their first language. Furthermore, incorporate these actions into the Faculty Equity Advisor Program and the Staff Equity Advisor Program
- b. Inclusion of AAPI in the UCSF-wide process improvement to disrupt the unconscious bias present in our hiring and promotions processes
- c. HR to make salary review a transparent process for AAPI staff, especially AAPI women, and to establish a salary review program for AAPI to ensure and achieve salary equity

## 5. Include AAPI When Using the “URM” Term in DEI Initiatives and Communications

There has rightly been much attention to minoritized groups that are URM. Relative to the [36%](#) of AAPI population in San Francisco, there is, by definition of the URM, an **underrepresentation** of AAPI faculty at UCSF at [27%](#), especially at the non-senior and non-executive levels. Some AAPI faculty have experienced barriers to advancement and promotion related to implicit biases and structural racism. By not adopting the updated AAMC’s URM definition and using a more nuanced approach to include the AAPI population, UCSF has applied the term incorrectly and discriminates against its AAPI, and by not using a more nuanced approach to include the AAPI population, UCSF further perpetuates the model minority myth and the invisibility of AAPI. We recommend:

- a. UCSF to use a more nuanced approach in using “URM”. There are circumstances by which using alternative language to “URM” would be more appropriate (e.g., BIPOC, minoritized) to include AAPI staff
- b. As a correction, UCSF to adopt [AAMC’s current definition](#) of URM to replace the outdated one currently [in place](#) at UCSF
- c. Classify applicants/faculty members who can speak Asian language(s) (especially those who meet UCSF’s 5% threshold language requirement) as URM
- d. UCSF will take leadership and recommend a., b., and c. above to the UC Regents to adopt across the UC Health system

## 6. Student Pipelines and School Admission

To meet the diverse language needs of our patients, in addition to the considerations for BIPOC, applicants’ bilingual skills in the threshold languages (especially Cantonese, a language deficit which has a huge gap between providers and patients) need to become an additional preference. This will help UCSF to be more in concordance with the language needs of the 35% AAPI in San Francisco (with about half of the AAPI immigrants experiencing language barriers). We recommend:

- a. Build student pipelines of future healthcare providers with bilingual abilities from the existing high school outreach programs, summer college internship programs, as well as clinical internship, residency and fellowship programs
- b. School admissions: UCSF schools will consider AAPI applicants as well as those with language ability meeting the 5% threshold language requirements as URM
- c. Data on the language ability of the students, in addition to their race and ethnicity, will be reported annually by each of the UCSF clinical schools e.g., Nursing, Medicine, Pharmacy, Dental, Physical Therapy, etc.