

The Pandemics of Racism and COVID-19: Danger and Opportunity

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Coronavirus disease 2019 (COVID-19) is a recent crisis. Racism is an enduring crisis that is inflamed in the presence of other crises. The Chinese word for “crisis” is composed of 2 characters, one signifying “danger” and the other, “opportunity” (Fig 1). The pandemics of COVID-19 and racism present clear danger. Our duty is to make sense of the opportunity by learning, understanding, and taking action.

In this issue of *Pediatrics*, Cheah et al¹ demonstrate the danger of these twin crises for Chinese American families. They surveyed parents and their children who reported a high rate of recent racist experiences, both in person and online. They also found a correlation with poor mental health. Like the subjects in their survey, the authors of this commentary (a Chinese American academic pediatrician parent and her daughter, a third-year medical student just starting her clinical rotations) have each experienced implicit and explicit bias and the rise of Sinophobia, both inside and outside the health care setting.

The findings in the article by Cheah et al¹ are consistent with a recent Pew Research Foundation study in which 4 in 10 Americans reported that it has become more common since COVID-19 for people to express racist views about Asian Americans. Both Asian and Black Americans were more likely to report adverse experiences due to their race or ethnicity since the pandemic’s beginning, including observing people acting uncomfortable around them, being subjected to slurs or jokes, and fearing threats or physical attack.²

Reports of racism and physical attacks on Asian Americans have increased markedly in the United States and worldwide.³ Their finding of a link to poor mental health should be no surprise.

DANGER

The COVID-19 pandemic has had far-reaching effects around the world: instilling fear, taking lives, and dramatically altering daily life. With danger comes the search for blame. History is rife with examples of heightened bigotry and xenophobia during crises. There is a long legacy of anti-Asian American racism in the United States, including the Chinese Exclusion Act in the 19th century, the first law that banned immigration on the basis of race. White nativists spread propaganda about the “yellow peril,” labeling new arrivals unclean and unfit.⁴ The internment of Japanese Americans in the United States during World War II is a sad example of xenophobia during war. In total, >120 000 persons of Japanese ancestry, of whom 62% were American citizens, were forced to relocate and were incarcerated in concentration camps from 1942 to 1945. The 1982 murder of Vincent Chin was an example of economic strife triggering unchecked racism and violence. Chin was beaten to death with a baseball bat by 2 autoworkers who thought he was Japanese; the murderers received a \$3000 fine and no jail time. During the severe acute respiratory syndrome outbreak, members of the Chinese and Southeast Asian communities in

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Canada, including health care workers, felt that the media directly racialized the disease, leaving their communities vulnerable to blame and discrimination. During the current pandemic, Asian American doctors and nurses have reported fighting racism and the coronavirus inside and outside the health care setting.⁵

A more subtle yet pernicious problem is the stereotyping of Asian Americans as a “model minority,” a group whose members are perceived to achieve a higher-than-average degree of success through some combination of innate talent and pull-yourself-up-by-your-bootstraps hard work. Unfortunately, this labeling ignores the heterogeneity of the population and is frequently used to pit minority groups against one another and blame victims of racism for the resulting circumstances. In fact, racism based on skin color, language, physical features, or other characteristics influences success and is dangerous for all groups.

Of course, living with racism in the United States has been part of the lives of African Americans for > 400 years, of American Indians since the continent’s “discovery” by Europeans, and of many other groups. COVID-19 has revealed once again the disproportionate impact of national trauma and crisis on poor and marginalized communities, another example of the deep intertwinement of race, socioeconomic position, and health in our society. It is no accident that the Black Lives Matter movement has arisen at this moment and is finally getting the attention it deserves.

OPPORTUNITY

Crisis also presents opportunity. We have seen incredible teamwork, innovation, and commitment to



FIGURE 1
The Chinese word for “crisis” is made up of 2 characters: danger and opportunity.

change. Looking forward, what can we do to ensure that we seize the moment and embrace positive change? As child health professionals, we have the opportunity and privilege to shape child health and well-being, establishing the foundation for adult health. We also have the responsibility to understand and address the health needs of our patients, including the scourge of racism. We have the stature to advocate for policies and initiatives that address biases and inequities. The American Academy of Pediatrics policy statement “The Impact of Racism on Child and Adolescent Health” outlines how pediatric professionals can address the effects of racism on children and adolescents. It calls for us to optimize clinical practice, improve workforce development and professional education, strengthen research, and deploy systems through community engagement, advocacy, and public policy.⁶

A critical first step is to learn about the history of racism and how it might affect our patients and families, both individually and structurally. Parents and schools must teach children about bias and racism; crucially, this requires acknowledging our country’s fraught history of exploiting racial and ethnic minorities. We must strive to understand how race, as a social determinant of health, has been and continues to be correlated with poorer health outcomes across

a plethora of pathologies, groups, and circumstances. A second essential step is to learn about and address our own biases, which affect not only patient interaction but also medical training and workplace conditions. Tools such as the Implicit Association Test (<https://implicit.harvard.edu/implicit/takeatest.html>) offer a good starting point. Clinicians must also lead the way in advocating for more racially just systems as well as providing a safe and culturally competent space for understanding and ameliorating the damage.

CONCLUSIONS

Addressing racism is necessary to achieve health equity. This month’s article on Sinophobia again calls us to action. As the United Nations Secretary-General Antonio Guterres states, we must “act now to strengthen the immunity of our societies against the virus of hate.”³

ABBREVIATION

COVID-19: coronavirus disease
2019

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