Data disaggregation: Why counting is crucial—Part I

Featured topic and speakers
In this episode of AMA Moving Medicine, experts discuss the importance of the data disaggregation among Asian American groups and how the current structures have led to health inequities.

Speakers

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Moderator

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Transcript

Unger: There is extensive diversity among communities such as Asian American and Native Hawaiian Pacific Islanders—and consequently, their health behaviors, beliefs and challenges deserve distinct attention.

Dr. Yap: How are we actually breaking down and trying to gather more so that we know more and support the political movements towards more disaggregation support when people bring up, let's actually fund money towards this because it's not cheap. That's part of the reason why data disaggregation hasn't happened. It's because yes, it is expensive. Yes, it takes more work but that more work in that like that more money that we put into it ultimately ends up in better health outcomes. It ultimately ends up with us having a stronger and a better community. And one that is more accepting and supportive of everyone who comes into this country.

Unger: That is Dr. Anna Yap, emergency medicine resident at the UCLA Olive View. On this episode of Moving Medicine—a podcast from the American Medical Association—Dr. Yap and AMA Senior Policy Analyst Joaquin Baca discuss how aggregating data has created structural health inequities in
the U.S. and how disaggregation is necessary for physicians to fully attend to the unique needs of AA and NHPI patients. I'm your host, Todd Unger, chief experience officer at the American Medical Association. Here's Joaquin Baca.

Baca: Thank you for joining this episode of Moving Medicine. I'm Joaquin Baca, a senior policy analyst at the American Medical Association. I'm joined today by Dr. Anna Yap, emergency medicine resident at UCLA Olive View. Today, we'll discuss the foundations that aggregating data in the United States has set in creating health inequities and the barriers physicians face in attending to the unique needs of Asian Americans and Pacific Islander patients. Thank you for joining us, Dr. Yap.

Dr. Yap: I'm Dr. Anna Yap an emergency medicine resident at the UCLA Ronald Reagan Olive View program. I come from an immigrant family, Chinese Malaysian. When my parents who came over and learned to be a nurse and a physician assistant who encouraged me to become a physician. And I've been so lucky to be part of organized medicine from day one of med school, knowing that I came into medicine being excited about health inequities and wanting to target the structural inequities that we see in America. And in that journey, I've been embracing more and more my Asian American heritage and what that means to practice in medicine and what that means to be a citizen who has an Asian American background. I'm really excited to bring that to the table today.

Baca: For Asian American and Pacific Islander—I think we should separate those as it is being done more commonly now—native Hawaiian as well to collectively comprise the largest and fastest growing racial group in the United States. But our data systems and infrastructure don't fully illustrate the complexity of the different experiences that lead to distinct health outcomes. Why do you feel like, Asian American, Pacific Islander and Native Hawaiian data is crucial? There's extensive diversity in that group and consequently their health behaviors, beliefs and challenges deserve to see distinct attention. Can you tell us a little bit of what you think about the need for disaggregation of data and where it comes from and some of those structural issues?

Dr. Yap: So, we as physicians, we as scientists, we work on data ultimately to really change anything or to direct what we do. Data's important. That really kind of drives why we need to make sure that the data we get is correct. If you look at the world, Asians, in general, make up 60% of our population but yet we lump all Asians, especially in America, under this kind of "Asian American" umbrella. And it kind of erases all the different things that we've been exposed to as immigrants in this country. We're such a diverse population that, unfortunately, because of the past in America, we had to come together and say, we're just going to be called Asian Americans to try to fight the history of being called "Oriental" and that's where we as a political group came together.

But since then, we've been able to really look more at what how important it is to have different information or different data about each different each of the different groups. I mean, the perfect example, I think of this, is just looking at like our educational backgrounds. So you can say that if you look at like in California, 70% of American Indians, 25 or older hold a bachelor degrees while only...
10% of those Laotian Americans do. And unfortunately, because we have this model minority myth that all Asians apparently do well, they'll go to higher education. Or there are more of us in higher education than the percent of us in the actual population we tend to think that all Asians go to school when realistically, when you actually break out the AANHPI community, that's not the case.

And that's just like one tiny example of all the large ways in which we're just all so different. There's been a long history in America of when Asian Americans have immigrated from the various countries and in what situations we've immigrated from our countries, whether that be earlier on during like the gold rush in America, when you have a lot of Chinese people coming over to work or later, or closer to now, like after the 1960s where you had a lot of Asian Americans come over from Asia to work more in the health care industry, especially looking at Filipino nurses who came over and then you also now look at the refugees nowadays who are coming over displaced from their countries. And unfortunately, they're part of the poorest communities here in America. And they oftentimes get erased when we look at APPI community for APPI data.

Baca: And I wanted to ask a little bit more about that too, because I think within … just the aggregation of data is also with Indian American and in broad Asian grouping. And so that, does that complicate things as well?

Dr. Yap: The issue at the end of the day is that when we're looking at the AANHPI communities, you have east Asians, which oftentimes are more represented in higher education, then you have southeast Asians, then you have Pacific Islanders—and we all have such different experiences and different places where we've come from. And there's also just a very large difference in numbers in terms of how many of each group are in America.

Baca: Great. And can you share how this lack of disaggregated data impacts physicians serving these communities on a day-to-day basis like through electronic health records, health outcomes?

Dr. Yap: Yeah. So I think one big problem in electronic health records, this is that we just don't even have the language to be able to get the data that we need. And that's part of the big issue with a lot of the data we have nowadays. And it's great that we're making steps forward to really access that, to really changed that. In California, I believe in like 2016, 2017 actually passed an act to increase the amount of data that we're getting when it comes to AANHPI individuals. But they are kind of the leading state in the whole nation. When we were looking at data within EHRs within the health outcomes. Ultimately the part of the big issue with all of this is that some of the health care that we provide, quite a lot of health care that we provide does have like specificities when it comes to particular communities.

For example, treatment plans are different for AAPI and non-AAPI individuals such as hormone replacement therapy or bone marrow cancer treatment. And then the AAPI community also has markedly different health risks when it comes to hepatitis B for cancer, for cardiovascular disease...
among other diseases. And unfortunately, a lot of disease does get missed or just kind of ignored in the Asian American community. I don't think many people know this but Asian Americans actually have a median age of 36, which is slightly younger than the national average age of 37.4 years. And there’s a higher percentage of Asian Americans who actually don't have health insurance compared to white individuals in America. And we also have like 10% of the AAPI community that has diabetes compared to 8% of the general population. And then when you break that data down even more, it's actually 47% of American Samoans and 20% of native Hawaiians have diabetes.

And you wouldn't know this unless you actually broke out the data, disaggregated the data. We also have, especially on our refugee population, a large, large, large group having PTSD with a 62% of Cambodian refugees having PTSD and another 51% having major depression in the last 10 months. A lot of times from the refugee status. All this, all these different health outcomes that wouldn't be born out unless we look at the data and really have that data. But the problem is, is that oftentimes there’s a lot of barriers and excuses to getting the data, whether that be from individuals saying, “Well, we don't have enough people to grab from, or we don't have enough buy-in.” Oftentimes when we're looking at research in general, Asian Americans are left out of research studies. And so we might not even be able to talk about Asian Americans much less, break it down into it, disaggregated groups and look at them even further.

**Baca:** I'm sure that was particularly important during COVID then. And I've heard in particular around the development of the vaccine and treatments, that might have been a larger issue, not to mention the xenophobia and the different experiences that Asian American, Pacific Islanders, Native Hawaiians experienced during the pandemic specifically.

**Dr. Yap:** When we looked at xenophobia in America, xenophobia in general has affected, I think every sector, the AANHPI community but I think was especially rampant in the east Asian communities, those who presented most as those who could be part of China and where a lot of this hate and vitriol kind of was directed to, whether it be our past president calling it the Chinese virus. I have stories of co-residents who took care of patients who I had. We had one patient come in, they were an Uber driver who—this was pretty early on in the pandemic—who was really concerned that they could have the Wuhanese virus because they drove a Chinese person in their backseat who had a Wuhan accent. And so then they were sure that they would've gotten it. I myself, during the pandemic, when I was working had a patient who initially was nice to me but when realized I was Chinese-appearing started yelling at me about how my people were making everyone sick and how we stole everything from him and we're eating all the rice.

And it just kind of made it a very, very hostile encounter. I've had friends from my hometown in SoCal who had family members who were screamed at when they were in line at Costco for saying that, you know, they were making everyone wear masks and that it was their fault that we had this pandemic. And it's definitely been tough on our communities, especially in so much as the Asian American...
community is disproportionately represented in health care. And in this pandemic, we've been working so hard to fight against this pandemic and it's really disheartening to be targeted and to be hated just for our race. And oftentimes many of us may not actually have come from the countries, we may not have lived in the countries in which people associate us with because of what we look like. And yet to carry that burden of being hated for what we look like while still trying to provide care has been particularly rough in the, in the community. For sure.

**Baca:** Absolutely. And it's horrible. And ... but it does bring up a really good point that maybe we could break out a little bit more. I think what you're bringing up is there's a lot of interpersonal racism and discrimination that's going on based on some of what you've described but there's also the larger systemic and structural pieces that are really endemic to all the way that this aggregated data as has really compounded problems. So and including in that there are state and federal data repositories and points where there may be gaps or the systems are broken such as like the census or through NIH or other data collection. Can we switch gears a little bit and talk about organizations that you see? Do you see those gaps as well?

**Dr. Yap:** Let's just talk about it at the national, at the federal level. Four years ago, there was a big push to have the census actually break down and desegregate communities. And unfortunately, it was shut down. And so, our past census, we just had was conducted similar to the one we had in 2010. And I mean, if we don't have buy-in from the federal level, from where the most basic of information should be, worth our census information, how is the rest of our data going to follow suit? And that's ... I mean, we need to have the political will to do this. And we unfortunately just don't I'm glad that the AMA has put forward the report that we put forward, hopefully helping to kind of shove that needle just a little bit. Like I think a lot of Asian American physicians I've talked to have been like, “Yeah, we need to be having more data.” And it's great that our institutions are seeing that and moving forward and supporting that.

**Baca:** Thank you, Dr. Yap. And I would mention with the strategic plan to embed equity into medicine through the AMA's plan is not just the Center for Health Equity’s plan. We did try and go through a lot of history and, in particular, I helped with some of the policy work or looking at how policy affected some of this. One of the things that I had done early for Dr. Maybank was to look at kind of a history of policy and I started with African American and Native American policies and how it affects health outcomes today. But I also did one and there's a timeline at the end of the strategic plan that may be of interest that does look through a lot of the history of policies that negatively impacted Asian American, Hawaiian, Pacific Islanders in particular.

And some of the policies that were passed—and this is where I was thinking from a systemic standpoint and a structural standpoint—that putting policies like this in place have huge ramifications and especially over time. So but you know, one of the earliest ones was that the county ... there was a California law in 1858 that was passed to bar Chinese and Mongolians, the way they termed it at
that point, from entering the United States. There’s also, of course, the major things like the Chinese Exclusionary Act and the Japanese camps that were established over the years. There was immigration stations that were set up specifically to monitor the number of Asian Americans entering the country. And one of the other things I found in some of the research that I did was one that the establishment of the border patrol was to find and to try and keep Asian Americans from entering the country at our borders.

But I do see how all this has created and compounded issues of how data is aggregated but also how it has been done very intentionally and purposefully to oppressed specifically different segments of the population in having the best outcomes they can have, not just in health, but in every arena that we could think of.

**Dr. Yap:** I’d like to point out that, like the Chinese Exclusion Act, these things codified in law. I really like that these are the only actual laws in American history that have specifically called out a particular group, a particular racial group to say you’re not allowed to come into our country. Then after they removed that specific or particular group and who they were, it was still baked in the policy, whether that be the number of Asians who are allowed to immigrate over by numbers of quota and issues around that. So, when you have that built into the history of our country, in terms of what we decided can be laws and cannot be laws, of course it’s going to be difficult to overcome that structural racism that has been in place as well.

**Baca:** Absolutely.

**Dr. Yap:** I'd like to talk a little bit about how we conceptualize what Asian Americans are which has unfortunately been part of the barrier to why we've been having such a hard time disaggregating and really coming together as a community, to take care of each other. I mentioned before this model minority myth, this idea that if some Asians can make it, then all minorities should be able to make it. It's been used very easily to uplift the Asian Americans that fit that box to then just ignore what's going on everywhere else. I think that it's also been used as a way to have Asian Americans who would not hop into the political sphere as much when it comes to racial issues, when it comes to speaking up about how health equity because it's just been weaponized against us because if we don't … if we speak up against the system that says or that tries to put us up as somehow better than them, we may somehow not benefit from it either. Of course, it is all speaking from my background as somebody who is Chinese-appearing but truthfully, I don't really identify with a lot of what China is. I've never been to China, myself. My family is Malaysian. We come from Malaysia. We speak, we speak many different languages. And we were taught that, we kind of mentioned about how does it feel or what boxes do we check when we're looking at, when we're trying to give ourselves our identity? And oftentimes I'm checking Chinese and other because I don't really feel like I'm Chinese so much as I feel like I'm Malaysian. And that's like southeast Asian but we don't typically have that box to check. And then even within Malaysia, you have racial issues there but you have like a
Chinese-appearing population and then you have a Malay-appearing population.

And I don't know where my family came from, they're both from Malaysia. I know they were displaced sometime during the many wars that have happened. But there's so much complexity there as well. And when you look within Asian American communities, there actually is a lot of antagonism between different communities as well. My mom, my family, they're wonderful and they're very accepting wonderful humans, but they do talk about the fact that the Japanese really did hurt our family. My grandma has a lot of PTSD from the fact that her parents, her uncles and aunts were killed during war too in front of her, by the Japanese. And so there's a lot of history there as well. And so when we lumped together all Asian Americans, we also erase the very rich and complex histories we have had ... our communities have had with each other across history and across time.

Baca: That's so important too because it's also about the tendency to erase culture that happens in the United States. So sometimes the great melting pot can be something that is not really considering the richness of all the different cultures that might go away or it might be erased in that process. So what you're bringing up is extremely important to, in the larger context of how culture plays out and also how culture plays a big role in wellness. And then some of the richness that's involved in the cultural practices gets lost that way as well. Do you have any thoughts about that?

Dr. Yap: Yeah, so for my family, we grew up in an Adventist church, which is a Chinese church. And there was actually a lot of Malaysians there and it turns out that that church was made up of a lot of individuals who also had immigrated from Asia in order to pursue a life here. And it kind of fell into going to health care, specifically going to nursing. At the time that my parents immigrated over in the seventies or eighties, it was the time when we were recruiting hard for nursing. And so in Loma Linda, where my family is from, we just ... we had a good little enclave of Chinese individuals. A lot of them actually from Malaysia, and that's where I got to have, we got to have ... All cultural groups, whether that be in Chinatowns and Koreatowns or whatever towns we're from but for us, it was based in this church because it was also the organization that helped sponsor us in our family to be able to have visas and to be able to work in this country. I remember growing up and having this church was really wonderful because we got to celebrate holidays that you wouldn't necessarily celebrate. In America, we had our Chinese New Year sometime, usually in February because we follow the lunar calendar, and we'd have Chinese school every Sunday. We'd try to learn some Chinese. And like for somebody, for me, actually, Chinese was my first language specifically Mandarin but going to school, it kind of disappeared because I was made fun of, for speaking it. I was made fun of for having rice in a rice box that my dad so lovingly prepared because it sounds funny or it didn't look right.

And so trying to navigate what it meant to be Asian American in America was really difficult and still is difficult. I think the journey of coming to terms with what Asian American means and what that means for my professional life and why knowing my Asian American Chinese-Malaysian history, all that has come a little bit later in life because they spent much of the earlier part of my life wanting to just like
assimilate and be able to succeed and wanting to just do well. Many times that is, not necessarily congruent with accepting and embracing what your culture is. So I will say that I feel like I'm still a baby in this sphere because there's so much to learn and so much that we're not taught in school, so much that we don't talk about.

We don't really talk about the internment camps and the fact that we took away the livelihoods of so many Japanese Americans, who were then at the end of it all were expected to just accept it and go back to trying to live life again despite the fact that America, that their country took away everything that they had. We don't talk a ton about the Chinese Exclusion Act. We don't talk a ton about the structural racism that's been in place against Asian Americans because, first of all, it's not written about, it's not taught largely. But also, oftentimes it's kind of erased in order to be like, “Well, but you're still doing well anyway, so it doesn't matter.” There's a lot of that as well.

**Baca:** No. And that does lead to intergenerational trauma. It leads to the inability to build a wealth over time and then has major repercussions on, you know, from a social determinants of health perspective many of those factors. So the resilience of people is … it still astounds me because, like you were mentioning, for the Japanese internment camps of people who lost everything. They had successful businesses; they work. You're really starting to accumulate wealth, potentially, and all that was just taken away and people had to start from scratch. And it's really horrifying to imagine that people had to go through that and are still recovering from that in many ways. And how that has a major impact on the mental wellbeing of so many people, just like you were describing at the beginning, of the statistics, of people that have PTSD from lots of different situations, and refugee status included, but depression and all these other forms of behavioral health that have been compounded through all these other bad policies. So, excellent.

The whole point of the classification of race has basically been more about exclusion than about how to count for the benefit of populations. So I think, you know, that from the very origins of how data was collected, it really was meant to put people into categories. It was never really meant to benefit populations. It was more, or if it was, it was almost as if people were being treated as commodities or as you know, protecting, we’re protecting the ability to produce material goods. And that's kind of at the source of why we would need data on specific populations.

I can say from a public health standpoint, as another example, we worked at the tumor registry and that cancer is a reportable disease. And so the data on race and ethnicity becomes very important from a surveillance standpoint how diseases affect different people but just like it was described earlier, when you lump everyone together, you wouldn't know the difference between those that have died, like it was described with diabetes—I think you mentioned two populations, one experiences 20% and one experiences at 44% but when they're lumped together, it’s kind of lost.

And so I think it's the same with all data collection, like in cancer surveillance or whatever it may be that the data collection becomes imprecise and not that helpful. But from another perspective, if
you're using it just to kind of monitor a larger group, then that may be helpful to that group but not to the individual groups that really could benefit from the disaggregated data.

Dr. Yap: Yeah, I think when it comes to data, when we don't have it, then we don't know to even look at it. My example for this is like HIV and Asian Americans. First of all, like sexuality is very taboo in many Asian American groups or maybe Asian groups, just flat out. But we don't actually realize that more than one in five Asians living with HIV don't even know it. And we don't talk about it. That's a big problem in the Asian American community. I know there's been many great groups trying to target those kinds of issues. There's been a high prevalence of hepatitis B, with chronic hepatitis B. And it's like one in 12 Asians, I believe, have chronic Hep B but they don't know about that. And we ended up having quite a lot of liver cancer in Asian American groups.

Mental health is another huge thing that we don't talk about a ton in Asian American groups. And I talked about the PTSD and the depression that we have in these, in our biggest refugee communities. But even in our non-refugee communities and growing up as an Asian American myself, like you don't talk about mental health. You don't talk about accessing that. The rates of suicide are actually quite high in Asians but we don't talk about that because we are supposed to be a model minority, because technically when you group us all together as AANHPI, we actually have, “better health than the average American.” We don't think about the health inequities that come with being Asian American in this country.

Well, you disaggregate the data and this was coming out of a study in California—I believe in the past year or two—when we looked at Vietnamese people who responded to the survey, they actually responded that they were in fair or poor health, more than twice that often than non-Hispanic whites and Asians overall. Oftentimes, we think that Japanese individuals are really healthy but in fact there was actually a higher proportion of people who are obese and overweight, and obesity … and being overweight is a huge taboo in east Asian countries, in your lighter skinned colored countries—the Japanese, the Chinese, the Koreans, the individual groups. But you kind of ignore the obesity that does happen in those groups, the diabetes that comes with that, the hypertension that comes with that. I know growing up, I was a more obese child and was made fun of incessantly for it. In fact, I had a lot of self-esteem issues that came around that because obesity was seen as a moral failing, whereas in many other parts of the Asian American community that is a norm.

Our attitudes towards different states of being towards different health that we have is very different between the communities that we have. I think also part of this study of Asian Americans in California, ultimately Filipino respondents were in the worst health of all Asian subgroups, and they had a higher prevalence of high blood pressure, asthma, heart disease. So they have more medication usage. I know in my county hospital that I work at Olive View, I'll walk in and I spend more than 50% of my time working on a shift speaking Spanish and I'll come and I'll be like, “Ingles or Español?” And they're just like neither I'm Filipino. There was actually quite a large Filipino population that shows up
in my county hospital who are on HD [hemodialysis] or who have chronic medical problems.

I didn’t think a ton about it until I started working at this county hospital and saw many more of them there. And so you know, with this, at least I also grew up with this idea that Asian Americans are in general, a lot healthier than the general population but as I’ve become more in tune with learning more in health care and being a physician, I’m constantly just learning so much about the fact that disaggregation is so much more important than I could have ever realized as a younger child.

**Baca:** You did bring up a couple of things that I wanted to ask more about, if it would be okay. One of the other areas, specifically AMA, what we may be hopefully changing the Masterfile of all physicians on record. And even within that data set, of course, Asian American, Native Hawaiian, Pacific Islanders are lumped together, which also creates an issue just in terms of something that you mentioned earlier. Your parents were in health care and you became a physician but the number of physicians within specific population groups doesn’t necessarily match the population. And as you were mentioning, you’re speaking Spanish. And so meeting a deficit in some ways of physicians that may have that as their native language. But just knowing that again, the data of the number of how well physicians are representing their population or their cultures and communities is not well known because of the aggregation of the data there as well. What would your thoughts be on that?

**Dr. Yap:** That is a huge issue and why it’s important that we're having more, especially more NHPI physicians come up through the ranks within the AA and NHPI community. There's a huge disparity in who actually attains higher education. There are a disproportionate number of Chinese, Indian, east Asian individuals in higher education, practicing as physicians. But there are not enough Native Hawaiians, not enough Pacific Islanders, not enough of a lot of southeast Asian physician groups as well. And so we miss that. And then you have people like me where, unfortunately, I'm not great at giving care to my own community because I've lost a lot of what I think could have made me "more Malaysian" as an individual because in trying to assimilate more into our culture, I've lost a lot. Like I don't speak Malay. Honestly, when I try to speak Chinese, nowadays Spanish comes out because I grew up in SoCal and learned Spanish in my high school because Chinese wasn't an option.

And my parents also spoke English to try to assimilate better and to try to be able to have their jobs and be able to live the dream that they came here with. And so I also struggled with that personally, I struggled with the fact that I don't think I can provide care to the community that I really feel like I should. So we have a lot of that loss too, with our erasure of our culture with our younger individuals growing up here and not having a society that encourages them to live into their race and to keep their culture. We then lose that and don't get to bring that into our practice as much. And then also, because we have so many AANHPI communities who are erased or who are lost, or who are not recognized in their poverty, that they have higher than the national average or in the fact that they don't complete school at the levels that they should that like other Asian Americans do.

We don't necessarily have those pipelines in place as robustly as we hoped we could, there’s been a
lot of great work across the country now that we're realizing that, now we've seen that, to try to help uplift more, especially AANHPI communities and to uplift more of those individuals coming into medical school and to becoming physicians. And even though I'm relatively early on in my career, I am trying to make more of an effort to really help uplift med students and rising physicians who are part of these communities, to be able to have somebody who is a champion for them and who can help uplift them and raise them up and encourage them to know that their experience matters. That their backgrounds matter and that they, as a physician, bring so much to the table and once they're there to also have them bring others up as well.

Baca: That's great. And when you were applying to medical school, or in your pipeline, were there specific challenges that you encountered that you feel maybe made things more difficult because of your background, is that something that you felt … was something that happened with you specifically?

Dr. Yap: Yeah, to such a large degree. So my family doesn't come from generational wealth. My mom comes from a very poor family in Malaysia where they'd be lucky to have rice and soy sauce for meals and relied a lot, actually, upon the goodness of Christian groups who gave like charity in the Southeast Asian countries—there's a whole other topic I could talk about sometime. They sent my mom over here to America so that she could pursue schooling because in Malaysia it is a heavy, heavy Muslim country. And not necessarily one that was, at the time, well set up to support women attaining higher education. So she came over here and worked really hard, worked in many jobs to the bone, to ultimately become a nurse and to help bring my father over and to help support her family members also coming over to become … to make a life for themselves that they wanted here in America.

And growing up, I very much bought into this model minority myth and because I'm Chinese-appearing always bought into this idea that I wasn't going to get help or that there was already plenty of Chinese people in school, so I would have to work harder to be able to attain the same levels of achievement. And looking back now it's a very toxic way to believe but unfortunately it was just kind of what was shown to me. So it made me very much doubt myself. I only applied to UC schools, University of California schools from high school, even though I was third in my school of like 3,600 students because I thought that I wouldn't or wasn't going to be good enough to be able to get into the ivy leagues or anywhere else. And so UC schools are just where I was going to go to.

And then I wasn't really able to get any financial aid or help. So I didn't think that it was wise for me to apply to anywhere but public schools because it was going to be the only places that me and my family would be able to afford. I am very proud of having gone to UC-Berkeley. I love it as a school. It is a wonderful place and doing a lot of wonderful research. So ultimately, I'm very thankful for having gone there but having that type of ingrained like racism and beliefs were very toxic. And I think, unfortunately, it has ingrained in a lot of sub-sectors of the AAPI community, specifically more of the...
Asian American community. You've seen the lawsuits against Harvard alleging that being Asian American means that we have to have higher SAT scores or have higher XYZ in order to qualify to go to school compared to other racial groups because of our prevalence or like overabundance in higher education.

And I think there are elements of that can be true and that's yet another barrier to having us all stand together as AA and NHPI to support each other and to uplift everyone. But definitely having that, like belief growing up stunted my, I think, what I could achieve in many, in some ways. And still, ultimately, I've gotten very far and I'm thankful for everything I've been able to do. But that's been something I've thought about more and been able to reflect on more. And I think having that like model minority myth also then can drive many other individuals in the Asian American community to feel like they're not good enough because they haven't achieved that particular whatever we're supposed to achieve. And I know growing up, I was told you should become a doctor or lawyer or an engineer or something like that because that's what you're told. You're supposed to become, at least in my particular like Chinese-ish experience. And I've had like family members who haven't attained that and have thus afterwards struggled to figure out what they're supposed to become because doors or professions that are possible or exists may not have been presented as one that is possible to us. So there's a lot of complexity tied into all of that as well.

Baca: Yeah. And I was just thinking of one other area that makes it more complex. I think, like your mom came over as a nurse, and then I wonder if it was on like a J1 visa but some of the policies that are around that as well can, you know, were and continue to be big, major challenges too. Specifically, Asian American, Pacific Islander, Native Hawaiian people want to practice medicine that are trained outside of the United States. And so even, there are structural barriers and barriers, I hear too, people that because they have an accent are treated very differently. They may not be able to get licensure or get advanced in their medical careers as easily because they potentially have an accent and things like that.

Dr. Yap: Oh, a hundred percent, like to all of them, our IMGs are so incredibly important. They provide the most care and underserved areas and go into the specialties that we don't fill, our primary care specialties that we don't fill. Our IMGs go in and serve in those communities. So these are so incredibly important but yet a lot of the policies that we're having aren't necessarily supporting them. We have a resident fellow member, who's an IMG, who's being deported back to their country because they couldn't get their visa to properly work. And so that's a ginormous issue.

So like I've firsthand seen where you having a different accent or where you look a certain way makes you not be respected. There's a perfect example where I had a Chinese attending who had a little bit of an accent and then had a white resident that was taking care of a patient, and every time the Chinese attending would say something, the patient didn't really like or recognize it until the white male resident said it. And they're like, “Oh, okay. Okay, doctor.” And there's been so many, like those
tiny microaggressions that we get as Asian American providers as pretty much any provider of color. I also see it with my Black colleagues as well. They're just ignored so many times because of the way they look or the way they present or the way they talk.

I had an intern when I was on the CCU, who actually came from the Netherlands. So they were white but they had a very strong accent, like other accent. They were an OB-GYN in their other country and they'd come over here to become a physician. So they went into internal medicine and they have their co-residents, their seniors, incessantly put them down or say that this person wasn't smart, or like behind their back to me be like, “Oh, I'm so sorry you have that resident. Like, he's not any good.” But I thought that he was one of the hardest working residents that I had ever had and that people overlooked, like how, what he thought or what he said because of his accent.

And yes, he may have taken a little bit long to explain things because of the way he spoke but ultimately had a lot of depth and a lot of smarts to the stuff that he proposed. But unfortunately, people around him couldn’t get over just how he presented differently. And we unfortunately have a lot of that bias within our health care systems, within our health care workforce in and of itself. And so it's wonderful that we, as the AMA, have a health equity plan moving forward, trying to break down those barriers so that we have data disaggregation for all races because that's so incredibly important. Also trying to break down the barriers that we have within each other when we as a workforce have. I want to say that data disaggregation, overcoming racism, in improving health equity and equity in our nation is so important for everyone.

It's not just an Asian American problem. It's not just a single group's problem but something that we as a nation have to deal with. And I think that's something a little bit more unique about us as a nation because we are a nation of immigrants. We've seen how incredibly important it is to have that as a segregation in all groups, especially like, for example, in this past election when we saw that Latin American groups are so incredibly different, when we looked at who was voting and how they were voting. We saw the Catholic, Hispanic or Cuban groups in Florida versus other voting Hispanic groups. That's an example of where it's important in a different racial category. So this data disaggregation is something that matters to all of us. It should matter to us as scientists. It should matter to us as physicians.

So we have a resolution coming through the AMA asking us to also disaggregate data for Middle Eastern North American individuals who also are ignored in all this. Like where do they fit in data? When we look at it, do they fit in the white subcategory? Do they fit in the Asian subcategory? We don't even talk about these other groups. So data disaggregation is so important for everyone. It's fantastic that we, as a scientific community, are starting to realize that more and more. And I just encourage everyone, whenever you look at data, just look at more and more, how are we actually breaking down and trying to gather more so that we know more. And support the political movements towards more disaggregation, support when people bring up let's actually fund money towards this
because it's not cheap. That's part of the reason why data disaggregation hasn't happened. It's because yes, it is expensive. Yes, it takes more work but that more work in and the more money that we put into it ultimately ends up in better health outcomes. It ultimately ends up with us having a stronger and a better community. And one that is more accepting and supportive of everyone who comes into this country.

60% of the world’s population falls under this AANHPI group. And so within that, you can just imagine how many cultures and countries and groups that are within that but yet we all lump it under that one. As like contexts to all that about 10% of the world's population is what we consider white, about 11% of the world's population is what we consider Black. So it's again, insane that we lump all of us under this single AAPI umbrella.

**Baca:** Absolutely. Yeah.

I think as a physician, and this is also from my bias as coming from … somebody who's from Southern California where there's a large Latinx population. I think the structures that we have don't necessarily support bringing up physicians that can really provide care to our AAPI communities, probably because there's just like a ton of different languages spoken within the AAPI communities. But also just the fact that they also live in many smaller enclaves are oftentimes seen as invisible. But I think that as we move forward, we should also look at having more like Mandarin or more Vietnamese or other like AANHPI languages offered in like high school, for example, because that was a big place that ultimately drove the fact that my Spanish is much better than my Mandarin at this point.

And so I can provide care to a Latinx speaker much better than I can ever give to a Chinese speaking individual. And thus, the care to my Chinese speaking patients are going to be not as great for me. Like I'm going to use a translator but realistically when I can speak to my patients, I ended up doing much better. And when we look at the data on how our racial groups are growing in America, currently the AAPI community comprises 6.1% of the overall U.S. population. But it's growing rapidly. The time between 2000 and 2015, we went from 11.9 million to 20-ish million individuals. So that's 72% growth during that time period. And AAPIs are supposed to project to surpass the Latinx community by 2055, then becoming the largest immigrant group in the country. But going back to the whole issue of AAPI is when we break it down, the whole community doesn't speak Mandarin or doesn't speak Cantonese or doesn't speak Japanese, they speak so many different languages.

And if we help to increase the amount of education we do for Asian American countries or what we can do culturally or learn culturally from these countries, we might then be able to actually raise physicians who can then also provide care to these communities. We might be having more white people who can speak Chinese giving care to our Chinese speaking individuals or Vietnamese serving Vietnamese speaking individuals. And not just have to rely on only hoping that we increase the pipeline, which we absolutely should and utterly should but that's not going to be, that shouldn't be
the only way that we are able to provide good care to our various patients.

**Baca:** Thank you again, Dr. Yap for being with us in today’s conversation about why counting is crucial.

**Dr. Yap:** Thank you so much for having me today and for letting me share my experiences as a Chinese Malaysian immigrant. And for giving me this platform to speak. I want to say I don’t speak for all AANHPI individuals and I’m, again, relatively early and young in this sphere but I think that each of our experiences are so incredibly important and I encourage everyone listening to this, to delve into your history, into your experiences and to really bring that to the table when you’re learning more. And you as physicians, you have so much to bring to the table with your background. And let’s all move medicine together.

**Unger:** You just heard from Dr. Anna Yap, emergency medicine resident at UCLA Olive View and Joaquin Baca, AMA senior policy analyst. I’m Todd Unger and this is Moving Medicine, a podcast by the American Medical Association. You can also subscribe to Moving Medicine and other great AMA podcasts anywhere you listen to yours or visit ama-assn.org/podcasts. Thank you for listening.

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