Committee News

Asian Americans: The Overrepresented Minority?

Dispelling the 'Model Minority' Myth

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Imagine the following real-life scenarios:

Scenario 1: "You smell like soy sauce!" my kidney transplant patient exclaimed. Several hours later, he insisted, "**No, really, you smell like soy sauce! I want to eat your coat off!**" I had eaten a meatball submarine sandwich with marinara sauce and provolone earlier.

Scenario 2: Another patient inquired before her colonoscopy, "**Are you related to Dr. Kim?**" I responded, "No, Dr. Kim is Korean American. I am Taiwanese American." "**Isn't that the same thing?**" she pressed. "**Well, your English is really good**," she said, despite my attempt to explain that I was born in Minnesota. *Uff da!*

Scenario 3: After discovering my husband was Chinese American, a well-intentioned coworker and friend told me, **"It's good you married your own kind."**

Scenario 4: "You people brought the virus. Go back to China." (asamonitor.pub/2YU4gak). The recent labeling of the SARS-CoV-2 virus as the "Chinese virus" (asamonitor.pub/2xRtpr6) has fueled outrage and acts of physical violence toward Asian Americans during the COVID-19 pandemic (asamonitor.pub/2xRc5m3). Ironically, findings from a study showed that most New York coronavirus cases came from Europe (*medRxiv* 2020).

The scenarios above illustrate the need to address conscious and unconscious biases toward Asian Americans as one homogenous group of foreigners. One of the biases that continues to plague Asian Americans today is the concept of the "model minority." It was first described in a 1966 *New York Times* article highlighting the relative success in assimilation of Japanese American immigrants (asamonitor.pub/2SRYpOT). This model minority myth perpetuates today with "generalizations based on surface-level analysis at the expense of more-refined and nuanced investigation" (asamonitor.pub/2Wr7Myp). My investigation reveals that in medicine, we focus on *underrepresented* minorities, which excludes Asian Americans as a group because we have become the *overrepresented* minority. However, we need to understand three systemic issues that continue to impact Asian Americans. First, Asian Americans are overrepresented in medicine in part because of immigration laws enacted in the past century. Second, Asian Americans are overrepresented due to generalized categorizations that lead us to overlook differences between ethnic groups and omit underrepresented Asian Americans. Third, Asian Americans are underrepresented in leadership positions, which affects their voice, visibility, and acceptance into American culture and organizations.

Asian Americans are overrepresented in the medical field because of immigration laws

The Immigration Act of 1924 created national origins quota designed to "preserve the ideal of U.S. [northwestern European] homogeneity" that completely excluded immigrants from Asia (asamonitor.pub/3btZXW8). More than four decades later, the Immigration and Nationality Act of 1965 preferentially allowed immigration of Asian doctors and engineers, leading to overrepresentation of Asian Americans within these professions (*Sociological Perspectives* 1992;35:673-704).

Here are some recent statistics:

- 15% of doctoral degrees in the U.S. are awarded to Asians (asamonitor.pub/3bu0qHS).
- 21% of medical school applicants are Asian (asamonitor.pub/35Xrga8).
- 19% of full time U.S. medical school faculty are Asian (asamonitor.pub/2LfXQKG).
- 17% of all active physicians identify as Asian (asamonitor.pub/3fDY3oR).
- 15-19% of anesthesiologists are Asian (asamonitor.pub/2Lws24B; asamonitor.pub/2WEZZoo; asamonitor.pub/2LwtxzL).

Despite comprising 5.6-6.8% of the U.S. population (asamonitor.pub/3fyZ6ql; asamonitor.pub/2yKQTi0), Asian Americans have a two- to four-fold higher representation in medicine, including anesthesiology. This overrepresentation contributes to the model minority myth that Asian Americans have succeeded in American society.

Asian Americans are the overrepresented minority because of generalized categorizations

In the same way that categorizing people as "North Americans" would neglect to recognize differences among Mexico, Canada, and Latin American countries, categorizing "Asians" similarly fails. For example, medical school applicants who identify as Asian comprise three predominant ethnicities: Indian, Chinese, and Korean (asamonitor.pub/3cny9DP). Anesthesiologists who identify as Asian are predominantly Indian, Chinese, Filipino, Vietnamese, and Korean in ethnicity (asamonitor.pub/2LwtxzL). Other Asian countries are underrepresented.

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Underrepresented minorities such as Thai, Hmong, or Burmese students are not even listed, and only 1.8% of Asian medical school applicants are Laotian, Cambodian, Indonesian, and Japanese (asamonitor.pub/3cny9DP). Generalized categories of race or country of origin ignore the importance of ethnicity. For example, the U.S. Census 2020 does not include a category for Taiwanese ethnicity (asamonitor.pub/2WsbjxU), despite the fact that Taiwanese medical school applicants made up 3.5% of Asian applicants in 2019 (asamonitor.pub/3cny9DP).

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Aggregating all Asian countries into one category ignores the unique differences between various Asian countries and ethnicities, some of which have been highlighted during the current COVID-19 pandemic. For example, one would expect the democratic country of Taiwan to be hard hit due to its location 81 miles off the coast of China and the numerous flights between the countries (*JAMA* 2020;323:1341-42). However, Taiwan learned from the 2003 SARS outbreak and equipped their Central Epidemic Command Center to restrict travel, establish quarantine protocols, encourage body-temperature monitoring, and ration mask distribution early in the pandemic (*JAMA* 2020;323:1341-42; asamonitor.pub/2WPr7RV; asamonitor.pub/3cA6NdG). Taiwanese innovators also introduced the aerosol intubation box (asamonitor.pub/2Yxtuoj), which has gone through multiple iterations in the U.S. as an additional protective barrier during tracheal intubation (asamonitor.pub/2WOQWkP). South Korea similarly learned from the 2015 MERS outbreak and was successful in flattening the COVID-19 curve with expansive testing, contact tracing, and enforced isolation (asamonitor.pub/3dDRWz0). Singapore, notable for its use of English as its primary language of instruction in schools (asamonitor.pub/35Qv4cW), was praised during the first wave for its social distancing measures (asamonitor.pub/2LpK8ot; asamonitor.pub/2WnGRwz). All this is to say that not all Asian countries are the same, and that categorizing Asian Americans into one category does not account for differences in ethnic origins, including the differing health systems and governance structures in each Asian country.

Census 2020 is currently under way; it uses race to allocate government resources and services. However, the U.S. Census is only as useful as the categories it contains. Omission, aggregation, and extrapolation

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of Asian American health data, for example, can lead to problems with interpretation (*Ann Epidemiol* 2012;22:397-405). President Obama identified the problem with aggregation and acknowledged the need for data collection and analysis of Asian American subpopulations in a 2009 executive order (asamonitor.pub/2Wo2Ral). Asian Americans do well economically, but analysis of 19 Asian American subpopulations revealed eight groups, including Hmong Americans, that had poverty rates higher than the U.S. average (asamonitor.pub/3bmEZsa). A large number of Hmong immigrant refugees resettled in Minnesota after the Vietnam War (asamonitor.pub/3fFWQ0s). Growing up, I remember the challenge my teachers had communicating with my friends' Hmong parents, who could neither read or speak English, nor read their own written language, which was first developed in the 1950s (asamonitor.pub/35S6WHe). Evaluation of subpopulations is critical for the fair distribution and direction of resources and services to underrepresented Asian Americans.

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While racial and ethnic identity remain important in medicine for genomics research, we should evaluate if these categories are useful for characterizing and developing our physician workforce in the current milieu of multiracial partnering. Projections for 2060 show that the fastest-growing group is the "Two or More Races" population at 226%, followed by Asians with a projected increase of 128% (asamonitor.pub/2WL4RbQ). In the future it will be even more important to disaggregate data collection for analysis and expand the scope of categories. Categories such as "first generation English native language," "first generation to college," or "income dollars per household member," may be more relevant in identifying subpopulations that need assistance with higher education, government resources, or political voice.

Asian Americans are underrepresented in leadership positions

The current 116th U.S. Congress has a record number of Asian Americans, but at 3.7%, is still underrepresenting the Asian population (asamonitor.pub/3cpdgs6). Some have described Asian Americans as the "invisible minority" (asamonitor.pub/2WkXLvz) while others state that Asian Americans are the "least likely group in the U.S. to be promoted to management" (asamonitor.pub/2yMkyaJ). Stereotypes and cultural differences contribute to this discrepancy (asamonitor.pub/2LlfLj6). These cultural barriers and biases contribute to the glass ceiling for Asian Americans in leadership and are referred to as the "bamboo ceiling" (*Breaking the Bamboo Ceiling: Career Strategies for Asians*. 2005.) The percent of Asian Americans in leadership positions such as anesthesiology department chairs, professional society leadership, and editorial boards is unknown. If 19% of anesthesiologists are Asian American (asamonitor.pub/2LwtxzL), we should expect approximately one in five anesthesiologist physician leaders to be Asian American; however, this is not my personal experience. In fact, some leadership workshops targeted toward minorities do not include Asian Americans because they are not an underrepresented minority. In one example, I had to look up the brochure's definition of "people of color," a phrase that has provoked debate, to see if I qualified to participate (asamonitor.pub/2LmewjU). Unfortunately, for this particular career development activity, "yellow" was not considered a color, and I was excluded from participation because I did not meet their definition of underrepresented minority.

The phrase "underrepresented minority" was initially used by the Association of American Medical Colleges (AAMC)to refer to "Blacks, Mexican Americans, Native Americans, and mainland Puerto Ricans" (asamonitor.pub/2LgdINg). Following the U.S. Supreme Court's decision in *Grutter v. Bollinger* (*Grutter v Bollinger*, 539 US 306 (2003)), the phrase was changed in 2004 to "underrepresented in medicine" to refer to "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" (asamonitor.pub/2LgdINg). Since Asian Americans have a two- to four-fold higher representation in medicine compared to their numbers in the general population, they are not technically underrepresented in medicine, despite being underrepresented in leadership. Yet true representation should reflect voice and power, and until Asian Americans are visible at the highest levels of leadership, there is work to be done to break down the bamboo ceiling.

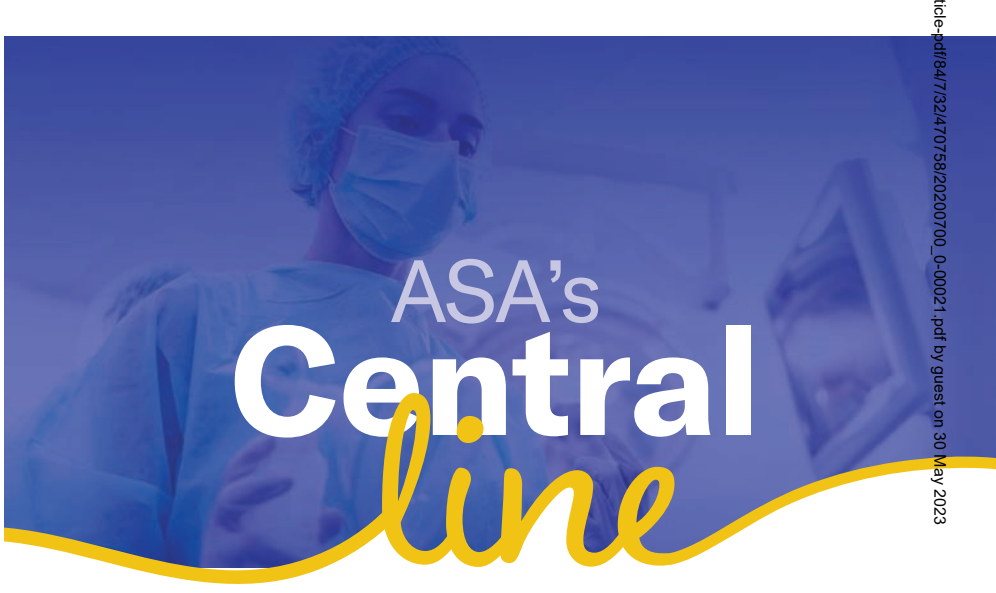
Diversity and inclusion efforts should address Asian Americans

Overrepresentation of Asian Americans in higher education (asamonitor.pub/3fHDIPu) and in the medical profession feeds into the model minority myth and can perpetuate stereotypes that continue to obstruct Asian American leadership opportunities. We need to understand our conscious and unconscious biases toward Asian Americans, collect and analyze data using disaggregated categorizations of subpopulations to include underrepresented Asian Americans (*SAGE Open* 2017;1-10), and work to promote Asian Americans into leadership positions.

How do we move forward?

1. **Talk about race with grace.** For many, conversations on race and ethnicity are uncomfortable because there is ample opportunity to offend and it can be extremely personal. Yet avoiding the topic entirely fails to address the issue. Let us start the conversation and extend grace to others as we share our personal viewpoints. We can agree to disagree.
2. **Perform root cause analysis on why race and ethnicity matters.** In the same way that future genotyping can help us create individual treatment plans, let's expand our view of racial/ethnic makeup to understand the effect of culture and environment on individuals and their career potential. We can open the scope and evaluate categories such as immigration generation and language background to analyze how these factors play a role in our decisions and opportunities (*Asians in the Ivory Tower: Dilemmas of Racial Inequality in American Higher Education*. 2010). We need to collect more data, pinpoint the problems, and then find solutions.
3. **Examine our personal biases.** We all have biases, myself included. To address them we need to bring unconscious bias to the conscious mind (through conversations about race or findings from research) and focus on re-training our minds and cultivating the minds of generations to come.

In the same way that Crayola has expanded their eight original colors, we should expand our outlook until we can see the full spectrum of color in American society. How we see and understand people can and should eventually extend outside the boxes of race, ethnicity, and gender, especially in workforce evaluation. I can only hope that in the coming decades my Asian American (asamonitor.pub/2Lh6E2Y) children will be seen as fully American and no one will be surprised at their English fluency. ■



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