The Not Underrepresented Minorities: Asian Americans, Diversity, and Admissions

Michelle Ko, MD, PhD, and Hendry Ton, MD, MS

Abstract

Several lawsuits have recently been filed against U.S. universities; the plaintiffs contend that considerations of race and ethnicity in admissions decisions discriminate against Asian Americans. In prior cases brought by non-Latino whites, the U.S. Supreme Court has upheld these considerations, arguing that they are crucial to a compelling interest to increase diversity. The dissenting opinion, however, concerns the possibility that such policies disadvantage Asian Americans, who are considered overrepresented in higher education. Here, the authors explain how a decision favoring the plaintiffs would affect U.S. medical schools. First, eliminating race and ethnicity in holistic review would undermine efforts to diversify the physician workforce. Second, the restrictions on considering race/ethnicity in admissions decisions would not remedy potential discrimination against Asian Americans that arise from implicit biases. Third, such restrictions would exacerbate the difficulty of addressing the diversity of experiences within Asian American subgroups, including recognizing those who are underrepresented in medicine. The authors propose that medical schools engage Asian Americans in diversity and inclusion efforts and recommend the following strategies: incorporate health equity into the institutional mission and admissions policies, disaggregate data to identify underrepresented Asian subgroups, include Asian Americans in diversity committees and support faculty who make diversity work part of their academic portfolio, and enhance the Asian American faculty pipeline through support and mentorship of students. Asian Americans will soon comprise one-fifth of the U.S. physician workforce and should be welcomed as part of the solution to advancing diversity and inclusion in medicine, not cast as the problem.

Editor's Note: An AM Rounds blog post in which the authors (M. Ko and H. Ton) discuss two recent developments relevant to Asian Americans, diversity, and admissions, is available online at http://academicmedicineblog.org/.

In November of 2018, litigators concluded their oral arguments in the case of Students for Fair Admissions, Inc. (SFFA) v. Harvard. The plaintiff, SFFA, alleged that Harvard discriminates against Asian Americans in undergraduate (baccalaureate) admissions. Founded by activist Edward Blum, SFFA is a legal advocacy organization whose mission is to eliminate the consideration of race and ethnicity in university admissions. SFFA has filed other suits, claiming anti-Asian American discrimination, against the University of North Carolina at Chapel Hill and against the University of Texas at Austin. Additionally, the U.S. Department of Justice has opened similar investigations into Harvard and Yale University.

Background

Claims of discrimination against Asian Americans in admissions decisions are not new. Several elite universities, including Harvard, faced similar charges from Asian American groups in the early 1980s. More recently, in 2015, the U.S. Department of Education investigated and cleared Princeton University of suspected anti-Asian discrimination in admissions decisions. In these cases, claims addressed negative action—that is, that universities disadvantage Asian Americans relative to whites. In contrast, SFFA contends that universities confer undue advantages to African American/black and Hispanic/Latino applicants through race-conscious admissions practices that, in turn, have harmful consequences for Asian Americans.

SFFA put forth the following arguments: first, Harvard’s holistic review process is a disguise for racially discriminatory practices; second, the university uses racial quotas; third, Harvard applies race illegally as a defining criterion for admission, rather than as a “plus factor” (as directed by the U.S. Supreme Court); and last, Harvard should use non-race-based methods to achieve its diversity objectives. To support its claims, SFFA noted that the enrollment of Asian Americans at Harvard has remained flat despite increasing representation among college applicants nationally. SFFA alleged that reviewers disproportionately describe Asian American applicants using negative stereotypes (e.g., “typical,” “standard,” “similar to many others”) and that Asian American applicants systematically receive lower ratings of their personal characteristics in Harvard’s scoring system. SFFA also presented its analyses showing that Asian Americans admitted to Harvard had higher academic scores, relative to African American/black and Hispanic/Latino students. SFFA concluded that to address anti-Asian American discrimination, the university should eliminate consideration of race and ethnicity as factors in its holistic review process.

Harvard denied SFFA’s allegations and criticized SFFA’s analyses along 2 lines: first, under holistic review, admissions decisions are based on multiple factors, such that comparisons of groups by academic scores alone are inappropriate; and second, SFFA did not analyze the entire pool of applicants. (SFFA excluded certain subgroups, including athletes and children of alumni and faculty,
who together make up nearly 30% of enrollment.) Harvard presented its own analyses showing that when academic and nonacademic factors are included with the full sample, the effect of Asian American race is not significant. The university further argued that considering race and ethnicity as factors in admissions decisions is essential for the university to meet its educational objectives for diversity. The presiding judge, U.S. District Court Judge Allison Burroughs, has indicated that her opinion will address only the allegations of anti–Asian American discrimination, not policies regarding holistic review.16 Regardless, each side has indicated that it will appeal any judgments not in its favor, suggesting that SFFA v Harvard will ultimately be brought to the U.S. Supreme Court.

SFFA v Harvard invokes the arguments brought by non-Latino white plaintiffs over the past several decades—from the seminal 1978 case against our own institution (Regents of the University of California [UC] v Bakke) to the 2016 update of Fisher v University of Texas (a case also funded and organized by Edward Blum). In each case, a non-Latino white plaintiff argued that by including race and ethnicity as factors in admissions decisions, universities unfairly discriminate against non-Latino white applicants. It is unknown how the current U.S. Supreme Court will decide cases with Asian American plaintiffs (vs non-Latino white plaintiffs), but the Court has previously upheld universities' right to consider race and ethnicity in admissions decisions, along with many other factors, given their compelling interest to increase student diversity. Notably, in his 2016 dissent, Justice Samuel Alito strongly criticized the University of Texas at Austin, stating the university's process granted advantages to African American/black and Hispanic/Latino applicants at the expense of Asian Americans.5 Following the second Fisher judgment in 2016, Blum sought partnerships with Asian American plaintiffs by meeting with Asian American organizations18 and by setting up recruitment websites (e.g., Harvard University Not Fair) and social media accounts (@HarvardNotFair) that feature Asian Americans.11–13

**Implications of SFFA v Harvard for Schools of Medicine**

The decision for SFFA v Harvard—no matter which party the decision favors—will have implications for U.S. medical schools. In contrast to the difference in the proportion of students applying to and matriculating into the undergraduate (baccalaureate) program at Harvard, the percentage of Asian Americans applying to U.S. medical schools is comparable to the percentage admitted (respectively, 20% and 21% for the 2017–2018 academic year).14 Nearly 12% of U.S. physicians identify as Asian, compared with 6% of the general U.S. population.15 From a proportionate representation perspective, medical schools appear unlikely targets for claims of discrimination against Asian Americans. However, because SFFA calls broadly for the elimination of race and ethnicity considerations in holistic review, a ruling in SFFA's favor would affect academic medicine in multiple ways.

First, as colleges and universities have argued repeatedly in cases stretching back to Bakke in 1978, eliminating race and ethnicity considerations undermines their efforts to improve physician workforce diversity.16 Introducing race-conscious affirmative action policies in the 1970s spurred an initial increase in the admission of African American/black and Hispanic/Latino medical students.17 Irrespective of Supreme Court rulings, 8 states (including our own [California]) have banned their public institutions of higher education from considering race and ethnicity in admissions decisions,18 and other universities and colleges have done so voluntarily.19 After these institutions eliminated considerations of race, enrollment and graduation rates of minorities underrepresented in medicine (URM) plummeted,19,20 and the steady progress to diversify medicine came to a halt.17 Of concern to medical schools, the number of science and engineering degrees conferred to members of URM groups declined11–13 as did the rate of URM group members graduating from highly selective colleges.18 When race and ethnicity considerations are removed from admissions decisions, medical schools face 2 constraints: (1) the applicant pool becomes less diverse and (2) they are unable to implement diversity initiatives in their own admissions processes. The only study (that we found) on race-conscious admissions in medical schools noted that bans on race-conscious admissions in 6 states led to a 17% drop in admission to medical school by members of URM groups.22

Second, a ban on race and ethnicity considerations is unlikely to counter potential discrimination against Asian Americans; that is, such a ban could actually exacerbate discrimination against Asian Americans. SFFA pointed to high Asian American enrollment at competitive California universities to suggest that Harvard should have comparable demographics.6 However, SFFA presented evidence only on enrollment, not applications, at California institutions. After Proposition 209, which eliminated race considerations in California public university admissions decisions, passed in 1996, the rate of acceptance into UC undergraduate (baccalaureate) schools for Asian Americans actually fell.21 The study's authors concluded that the rise in the absolute (raw number) of Asian Americans enrolling at UC schools was primarily driven by their increasing numbers in the applicant pool, not more favorable admissions policies.21 There has not been a similar analysis for California medical schools, which are more selective than UC as a whole. The proportion of Asian Americans enrolled at each of the 2 most selective UC undergraduate (baccalaureate) programs (Berkeley and Los Angeles) has declined since Proposition 209 passed (but remains higher than that of UC medical schools).14,24

The reasons for falling undergraduate (baccalaureate) acceptance rates in California remain unclear, but the lack of explicit guidance on race and ethnicity may expand opportunities for implicit biases to influence admissions decisions.5 Applicants' race and ethnicity, which are nearly impossible to obscure (whether revealed by names, participation in cultural organizations, or influential experiences that appear in a personal statement), inevitably shape reviewer evaluations. For Asian Americans, the predominant bias arises from the "model minority" stereotype—that is, that Asian Americans are quiet, hardworking, and most of all, academically successful.25 The model minority stereotype has been promoted as evidence for the absence of racism: if Asian American groups can be successful, then education cannot be biased and therefore those from other minority groups (e.g., African Americans/black, Hispanics/Latinos) should not be offered admission to schools through affirmative action.25 The stereotype conveniently avoids the historic legacy
of U.S. immigration policy which barred immigration from Asian countries for a generation and then initially favored only those seeking graduate and professional education, particularly in health care. Consequently, immigration among Asians was heavily and disproportionately weighted toward those with access to higher education in their home countries, those with advanced degrees, and those with higher incomes.

Such a “positive” bias can have negative consequences for admissions. Research in undergraduate (baccalaureate) education has shown that implicit model minority bias leads reviewers to subconsciously hold Asian American applicants to higher standards than other groups. Stereotypes of Asians as deferential and lacking in creativity also drive negative judgments about Asian American applicants. Harvard reported that their Asian American applicants received lower personal scores due to, on average, weaker letters of recommendation, suggesting bias on the part of teachers, coaches, and supervisors. Although, to our knowledge, no studies have examined medical school admissions, implicit bias theory argues that biases arise from pervasive societal stereotypes. No available evidence suggests that medical faculty would be somehow immune to these effects; on the contrary, a recent study of one institution’s admissions committee found that all members displayed significant implicit white preference.

Lastly, implicit bias could disadvantage specific Asian subgroups who are underrepresented in medicine. Whereas East and South Asians make up a higher proportion of physicians than their population representation, Filipinos and Southeast Asians (Vietnamese, Cambodian, Hmong, and Laotian) physicians are not overrepresented in the United States. Filipinos and Vietnamese constitute 25% of the U.S. Asian population but only 8% of the Asian American physician workforce. Those who identify as Cambodian, Hmong, and Laotian face substantial socioeconomic barriers. To illustrate, fewer than half have greater than a high school education (vs over 90% of other East and South Asians), and many among these subgroups experience poverty at higher rates than other URM communities. As with the “model” Asians, the educational prospects of Southeast Asians have been largely shaped by U.S. policy but by conflict, trauma, and forced migration. Southeast Asian college students, compared with their East and South Asian peers, are more likely to report negative racial experiences, lack of resources, and lack of representation on campus. Research on Asian American academic achievement has generally failed to account for differences by ethnic subgroups, socioeconomic status, immigrant generation, or English proficiency; lumping Asian Americans together in this fashion has contributed to the aggregate perception of academic success. Applicants from diverse Asian communities may be negatively evaluated by reviewers who are not aware that some Asian subgroups are underrepresented in medicine, who subconsciously perceive Asian Americans as overrepresented in medicine, and/or who expect higher grades and test scores from Asian Americans. These and other contrasting experiences across Asian subgroups illustrate the critical need for all applicants to be able to specify their race and ethnicity, factors that are fundamental to identity and life experiences.

Rethinking Admissions (Again)

Despite several decades of diversity and inclusion initiatives, most minorities other than East and South Asians have remained underrepresented in U.S. medical schools. Admissions reforms pursued in other countries, usually emphasizing socioeconomic status without an explicit focus on race, ethnicity, or health equity, have also resulted in minimal appreciable changes in diversity. Following the introduction of the Liaison Committee on Medical Education (LCME) diversity and inclusion standards in 2009, the matriculation of African American/black students into LCME-accredited medical schools rose only modestly. In other words, though medical schools may argue that a judgment in favor of SFFA would constrain their diversity efforts, the fruits of those efforts have been, heretofore, chronically insufficient.

The absence of meaningful progress may be due to ongoing debates, re-litigated by SFFA, that present conflicting interpretations of fairness: does inclusion of race and ethnicity in admissions considerations violate equal opportunity, or are such considerations acceptable if a university considers diversity critical to its educational mission? We believe both arguments are flawed because they frame racial and ethnic diversity as distinct and in direct opposition to merit. Medical schools have a public health responsibility to produce a workforce that meets the needs of the diverse U.S. population, and, by that measure, they are failing. The lack of diversity in the medical profession ensures persistent physician shortages in URM communities and disparities in access and quality.

We propose that schools of medicine explicitly incorporate population health equity into their stated missions. A public commitment to health equity would signal to applicants and faculty alike what constitutes merit among aspiring physicians: that diversity of experiences and perspectives is a core attribute—not a set-aside or a competing interest. Admissions policies should be developed to prioritize candidates by their potential for addressing health equity. Additionally, medical education at every stage (from the pipeline through medical school to residency training) should be designed to prepare learners to meet population needs. Mission-driven programs that specifically select and train students for practice in underserved urban and rural communities have demonstrated a long track record of success. In California, for example, the UC Programs in Medical Education (PRIME) are based on assessment of community health needs, and admissions policies and curricula are developed accordingly. The first PRIME program began in 2004 at the University of California, Irvine, with subsequent implementation across all UC schools of medicine; in 2019, 60% of PRIME students were underrepresented minorities. By adopting an equity-based mission, schools of medicine appropriately center academic medicine’s role in community health.

Moving Beyond Admissions: Diversity and Inclusion as an Alternative

Admissions discussions, both historic and current, perpetuate another problem: that is, other than in debates on higher education, Asian Americans are rarely mentioned in the U.S. dialogue on race. Model or not, members of Asian American communities are subjected to discrimination and harassment, and
those working in the medical profession are no exception. Even after adjusting for test scores, research experience, leadership roles, and community service, Asian American medical students are less likely than whites to be nominated for Alpha Omega Alpha membership. They are less likely to be described with standout words such as “exceptional” or “outstanding,” or caring words such as “empathetic” or “compassionate.” In a national survey of physicians, over 45% of Asian American physicians reported experiencing racial and ethnic discrimination in their professional lives. Having racialized experiences that repeatedly go unacknowledged leads to Asian Americans feeling marginalized and invisible. Asian American medical students have reported that the lack of role models and feelings of invisibility dampen their aspirations for careers in academic medicine, because “medical schools will just forget about us.”

Marginalization may inadvertently fuel Asian Americans’ advocacy against diversity and inclusion policies. If admissions are the only context in which Asian Americans receive recognition, then, unsurprisingly, some groups will perceive higher education as a zero-sum game in which their status must be rigorously defended. That is, if higher education is the only arena in which racial and ethnic groups can litigate racial grievances, then they will capitalize upon the opportunity to do so—even at the expense of their own members. For example, even though the majority of Asian Americans support race-conscious affirmative action, a 2016 survey conducted by the Asian Americans Advancing Justice Institute found only 23% of Chinese Americans describe college affirmative action programs as a “good thing,” versus 67% of Filipino Americans and 78% of Vietnamese Americans. Additionally, the Asian American Coalition for Education, the majority of whose board members identify as Chinese American, has endorsed SSFA’s lawsuits and has filed similar complaints of discriminatory practices against several Ivy League colleges and universities with the Departments of Education and Justice. Unless institutions of higher education, including schools of medicine, proactively engage Asian American communities, other voices will fill the gaps. Analyses of Chinese-language social media have identified a proliferation of false information on affirmative action, notably during a period when Asian American groups in California defeated a recent attempt to repeal Proposition 209. The question, then, is how the academic medicine community should address the nonminority minority. Rather than simply eliminating race and ethnicity considerations from admissions decisions, we propose proactively engaging Asian Americans in efforts to increase diversity and inclusion in medicine. Asian Americans will soon constitute one-fifth of the physician workforce. Steps toward inclusion are needed to change the dynamic of alienation and enable Asian Americans to use their own voices to define their place in relationship with members of other cultural communities. To promote Asian American engagement, we offer the following 3 recommendations: (1) disaggregate Asian demographic data; (2) include Asian American trainees and faculty in diversity committees, provide mentorship, and acknowledge the contributions of those interested in making diversity part of their academic portfolio; and (3) advance the pipeline of Asian Americans interested in academic careers through recruitment, student support, and faculty development.

Disaggregate Asian demographic data
Aggregated data contribute to the model minority myth and oversimplification of Asian Americans’ diverse communities. These combined data obscure the marked social and education disparities among subgroups. Universities serving undergraduate (baccalaureate) students have used disaggregated data, first, to identify Asian subgroups with disproportionately lower acceptance rates and, then, to develop policies to address potential inequities. Disaggregation has also been critical in identifying health disparities, such as markedly higher rates of cervical cancer among Cambodian and Hmong American women versus high lung cancer mortality among Chinese Americans. The Association of American Medical Colleges (AAMC) definition of “underrepresented minority” allows for institutional and community flexibility; medical schools should exercise the flexibility allowed and present their data on Asian subgroups. These efforts are necessary to identify local community health needs, those underrepresented in medicine, and applicants with the potential to address local health disparities. Explicit recognition of the plurality of Asian American students and faculty reduces the oversimplified and unrealistic myth of the model minority, which, in turn, benefits all Asian Americans.

Include Asian American trainees and faculty in diversity committees, provide mentorship, and acknowledge the contributions of those interested in making diversity part of their academic portfolio
Asian American membership on diversity committees and support of their efforts would allow them to add to the discussion in meaningful ways. True inclusion would emphasize what Asian American physicians contribute: insights from their own lived experiences as minorities, personal knowledge of issues more common in Asian American communities (e.g., the effects of war traumas, immigration, and resettlement), improved communication with Asian patients with limited English proficiency, and understanding of unique cultural healing practices. Bringing in Asian American voices would facilitate education within academic medicine on the diversity within the Asian American population and increase the number of role models for Asian American trainees and junior faculty members. All members of admissions committees, no matter their backgrounds, require training and development. There are currently no standards for training—in diversity and inclusion or other relevant skill sets—for members of admissions committees. Recent calls to institute implicit bias assessment and training should include discussion of biases against Asian Americans. Inclusion is also key for educating Asian Americans who may have limited prior understanding of the complex race and ethnicity dynamics in the United States and incomplete knowledge even of other Asian American communities. For example, the Asian American organizations that filed amicus briefs against race-conscious admissions more often characterized Asian Americans as East and South Asians and rarely acknowledged Southeast Asians and Pacific Islanders.
Enhance the Asian American pipeline in academic careers through recruitment, student supports, and faculty development

Diversity and inclusion efforts cannot succeed without the recruitment and promotion of diverse faculty in academic medicine. Asian American representation at senior levels is comparable to or even less than that of URM groups. Over the past 20 years, Asian American representation among medical school faculty has increased from 9% to 19%, whereas the change in department chairs was much smaller (growing only from 3% to 8.5%), and the total number of deans has increased from zero to one across all U.S. medical schools. The AAMC’s Diversity 3.0 initiative established online resources for supporting Asian American faculty and medical students in academic careers.

Recommendations include supporting Asian American medical student groups; proactively building mentorship; and encouraging Asian American participation in diversity programs such as Building the Next Generation of Academic Physicians events, the AAMC Minority Faculty Development Seminar, and faculty fellowships.

In Sum

Rulings in favor of the SFFA in its cases against Harvard and other universities could deal a substantial setback to efforts to improve diversity and inclusion in medicine. Furthermore, the admissions debate distracts from the more consequential discussion of the role of Asian Americans in medicine. Asian Americans constitute a growing proportion of U.S. physicians and are the fastest growing population in the United States. Rather than casting Asian Americans as contributing to the challenges in diversity, now is the time to include them as part of the solution.

Acknowledgments: The University of California Davis Office of Diversity; Equity and Inclusion supports Dr. Ton’s efforts in promoting policies and practices that foster a climate of inclusion and diversity.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

H. Ton is interim associate vice chancellor, Diversity, Equity and Inclusion, associate dean, Faculty Development and Diversity, and professor, Department of Psychiatry and Behavioral Sciences, University of California, Davis, Sacramento, California. He is also the senior author of this article.

M. Ko is assistant professor, Division of Health Policy and Management, Department of Public Health Sciences, University of California, Davis, Davis, California; ORCID: https://orcid.org/0000-0001-8859-0022.

References


