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SPECIAL ARTICLE

A Collaborative Reflection on the Model Minority Myth: Considerations for Recruiting, Retaining, and Promoting Asian Americans in Family Medicine

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EMBODYING THE MODEL MINORITY

> *"I was probably 5 or 6. My father was pumping gas just off the interstate close to where we lived when an older couple started yelling at him. 'Go back to where you came from. We don't want your kind around here.' This was the first time I learned about race—that I was different from everyone else. The Asian population of Utah at the time was around 2%. From that time, I was taught, 'The nail that sticks out gets hammered.' I was to be quiet, polite, respectful, and follow the rules. I became the 'model minority' society wanted to see. I participated in math competitions while in middle school. I took the ACT in ninth grade. Excellence was expected of me by teachers and classmates. I was the person people went to for math help and worked as a math tutor at the local community college as my job in high school. I thought being the 'model minority' was the only way to fit in with the predominantly White community, so I worked hard to be able to fit this mold."*
>
> —(M.K.C.)

The experiences of Asian Americans, including health care providers, are often overlooked because Asian Americans are not considered underrepresented in medicine.[1,2] In addition to not being categorized as underrepresented, Asian Americans are persistently viewed as the "model minority": monolithically academically successful.[2] The model minority has long been viewed as a positive stereotype and therefore presumed harmless.[3]

In this essay, we reflect on our collective life experiences to examine how the model minority myth (MMM) has affected

our lives as Asian Americans in academic medicine, and we propose that this myth must be resisted by the field of academic medicine to stop harming Asian American communities. The author team met at the University of Utah; we are all at various stages of our career, ranging from residency training, early-career faculty, to tenured professor. Five are family physicians (MDs), one a physician assistant (MPAS), and one a PhD educational researcher. Four are women and three are men. Six identify as Asian Americans. One identifies as a Puerto Rican American who has advocated for Asian Americans to be included in conversations and initiatives pertaining to diversity, equity, and inclusion (DEI). Despite our various backgrounds, we were alarmed by the increase of anti-Asian hate that accompanied COVID-19. Our shared goal of bringing attention to the discrimination that Asian Americans encounter and how that influences recruitment, retention, and promotion is what prompted this narrative. Here we discuss the history of the MMM, how it is damaging to Asian Americans and other racially minoritized communities, how it affects recruitment and promotion of Asian Americans, and what the family medicine community can do to work against the MMM.

We understand and acknowledge that we are not representative of all Asian Americans; specifically, none of us identify as Central or South Asian. However, we believe in the importance of shedding light on the experiences of an underresearched group. Our differing identities, different years of experience, different ethnic identities, and different areas of expertise are what enabled us to bring multiple perspectives to this essay. Additionally, we acknowledge that many of us embody the model minority, even as we are working to dispel it.

CONFRONTING THE MMM AND ITS HARMS TO THE ASIAN AMERICAN COMMUNITY

> "I first heard of the model minority when I was in middle school. At the time, I was confused what was so wrong with being the 'model minority.' I was proud of the work I put into my academic success; I felt grateful for the enriching experiences my parents provided me, including music and sports. What was so bad about being a 'good' kid who followed the rules?"
>
> *(J.L.)*

In reflecting on how we view ourselves as Asian Americans, we realized that we all shared this sentiment at one point. However, in time we learned that the model minority is a racial frame imposed on Asian Americans, coined by sociologist William Peterson in 1966.[4] Peterson stereotyped Japanese Americans as a rule-abiding and hardworking group that overcame the adversity of internment during World War II within 20 years.[4] Peterson's work used the success of Japanese Americans and the term model minority for a specific purpose: to refute Black Americans' claims of racial oppression during the Civil Rights movement.[4] Despite the fact that the model minority is an overgeneralization of Asian American success, it has persisted. The 1965 Immigration and Nationality Act allowed immigration of physicians from Asian countries, which contributed to the overrepresentation of Asian physicians in medicine and subsequently contributed to furthering the myth of the model minority.[5] Once we better understood this, we started to see the flaws of the MMM: how it downplayed the history of Asian American racism, erased the experiences of Asian American students who do not excel in school, minimized the struggles of underpresented Asian Americans in achieving academic success, and affected recruitment policies toward Asian American students/trainees and faculty.

Because so many, including Asian Americans themselves, accept the MMM as truth,[6] one can easily forget the explicit racism that Asians in the United States have faced. And yet, many historical examples exist, including several immigration laws that prevented Asians from entering the United States. In 1875, the Page Law[7] was enacted, forbidding Chinese women from immigrating. Shortly after, the Chinese Exclusion Act of 1882 barred Chinese immigrants from entering the United States.[7] The 1882 Act was followed by the Immigration Act of 1917, which prohibited immigrants from the "barred zone" of Asia, excluding only Japan (because immigration from Japan specifically was already prohibited) and the Philippines (a US colony).[8] In the mid-20th century, Japanese Americans faced forced incarceration for 3 years during World War II.[9] A rise in anti-Asian sentiment in the 1980s resulted in the murder of Vincent Chin.[9] Most recently, during COVID-19, Asian Americans experienced increased anti-Asian hate.[10]

The MMM also obscures the variation in academic achievement among different Asian ethnic subgroups.[11,12] In medicine specifically, Asian American students are well-represented as a whole,[5] but disaggregated data reveals that medical school applicants from Southeast Asian backgrounds (ie, Vietnamese, Cambodian, Hmong, Laotian) represent only 1.7% of applicants.[1,13] Despite Asian Americans representing nearly one-fifth of physicians, they are lacking in the ranks of leadership, including academic medicine positions such as full professors, chairs, and deans.[14,15]

Finally, resources may not be deemed necessary in serving Asian American patients (Table 1).

> "I feel I can uniquely connect with Mandarin-speaking patients using my basic language skills I gained from speaking Mandarin at home. However, I did not feel supported by my medical residency program to foster a skill I already possessed to treat patients in their native tongue. After multiple requests to different leaders in the organization, the program denied me opportunities to learn medical Mandarin due to the presumed lack of need in our community here in Utah."
>
> *(J.L.)*

Just as uneven academic achievement among Asian Americans is underrecognized, so are health care disparities in the

Asian American population.[16–18] Researchers often aggregate subgroups under one racial label: "Asian." In 2000, the US Census began separating Asians and Pacific Islanders, and in 2003 the Secretary of Human and Health Services created seven subgroups, one of which was "Other Asian." Current research primarily focuses on the largest Asian American groups, including Chinese, Japanese, Vietnamese, Korean, Filipino, and Indian.[18] Studies examining smaller subgroups remain limited. Not recognizing such disparities, or the need to effectively communicate with Asian American patients in order to prevent disparities, is another harmful effect of the MMM.[19]

CONFRONTING THE MMM AND ITS HARMS TO OTHER RACIALLY MINORITIZED GROUPS

> "I think it is important to recognize when this myth is being believed by non-Asians and used as a way to discriminate [against] others, not realiz[ing] that there is structural violence occurring that keeps non-Asian ethnic minorities/People of Color from having equitable opportunities and expectations, or otherwise contributing to racist attitudes/beliefs. It is also important to recognize that not all Asians (or other ethnic groups, for that matter) are the same, have the same background, culture, language, or experiences."
>
> *(M.L.)*

> "Once I had connected the dots, I started to link stereotypes affiliated with those who identified as Asian. Initially it seemed like overall positive remarks such as expecting us Asian students to excel in the sciences including engineering while being weaker in the humanities such as art. However, it wasn't until medical school that I realized how incorrect this concept was."
>
> *(T.F.H.)*

Another way in which the MMM is harmful is that it juxtaposes Asian Americans against other racially minoritized communities. Asian Americans can be a model minority only because they are framed as better than Black and Brown Americans.[20,21] In choosing solidarity with other communities of color, Asian Americans must denounce the privileges that come with being the model minority.[22] Although history of solidarity between Asian Americans and other racially minoritized communities exists, this history is not well-known and often left out narratives about Asian Americans.[9] Denouncing the MMM can promote better relationships among all racially minoritized communities.

THE HARMS OF LIMINALITY: EXCLUSION FROM RESOURCES AND RETENTION AND PROMOTION EFFORTS

> "The bias in medical education and higher education is palpable; it is not covert. It is institutionalized in admissions and other initiatives centered on educational equity. I find myself participating in EDI [equity, diversity, inclusion] committees that have initiatives that are exclusively centered on URM/URIM [underrepresented minority/underrepresented in medicine] communities. . . . I can only imagine that my multicultural affinity group views me as the model minority stereotype and that there is no need to include me or my identity-community to 'dance at the party.'"
>
> *(D.R.)*

> "When I first joined the organization, I was hopeful it would be a place where I could grow as both a family physician and a person. I envisioned building a long career serving patients, making a meaningful impact in communities that felt like home. . . . Over time, it became clear the organization was uninterested in retaining people like me. . . . Leaving was difficult, but it taught me a vital lesson: Organizations that neglect diversity and inclusion fail not only their employees but also their patients and communities. They lose talented individuals who could help them grow into something better. I carry this experience forward, determined to seek spaces where I—and others like me—are valued, supported, and able to thrive."
>
> *(M.K.C.)*

Asian Americans exist in liminality, as racially triangulated between White and Black Americans.[20] While we understand and believe in the importance of supporting underrepresented minoritized groups, not feeling caught in the middle is difficult, like we do not belong in White or Black and Brown spaces. As racially triangulated Americans, Asian Americans have dissimilar experiences to that of the racial White majority.[2] Asian Americans experience racism in various environments, including professional settings.[23] Medicine is not exempt; recent studies have documented that Asian American medical students[24] and providers[25,26] alike felt discriminated against during COVID-19 and unsupported by colleagues. Reported cases of discrimination rose sharply in 2020,[2] illuminating how Asian Americans experience racism, even in their roles as model minorities.[5] Another study illustrated how experiences with microaggressions and liminality are persistent issues for Asian American medical providers, not just isolated to

the pandemic.[27] The dangers of ignoring this sense of not belonging is that it can lead to disillusionment and feelings of invisibility.[1] Asian Americans are an important part of the primary care and academic medicine communities, and they can play a big role in making medicine a more equitable and inclusive environment. However, this will not happen if they feel ignored.[1]

Asian Americans are not considered underrepresented in medicine because a greater proportion of Asian Americans are in medicine relative to the number of Asian Americans in the general population.[1] In this context, the MMM is damaging because it can divert resources away from communities not deemed sufficiently minoritized.[28] For instance, Southeast Asian Americans have reported experiencing "quiet neglect" as US culture highlights achievements from East Asians and erases the needs of this underrepresented subgroup.[29] In turn, creating policies or practices centered around recruiting or retaining Asian American trainees and faculty may not seem necessary, which as the previous narratives illustrate, can result in feelings of exlusion within DEI committees, training programs, divisions, and departments.

CALL TO RESIST THE MMM

> "It is important for Asian Americans to resist this myth because it creates divisions—among Asian Americans and between Asian Americans and other People of Color. The model minority myth was created to divide communities of color in order to diffuse power. When we, as People of Color, are divided, we have no way to resist/fight/defeat White supremacy. But if we understand the origins of the model minority and how it is false, we can join together and have a bigger impact in fighting racism. It is also important for Asian Americans to resist the myth because the policies that are born out of the myth are detrimental to us. . . . Many Asian Americans who buy into the myth are opposed to affirmative action. However, research has shown that race-blind admissions processes largely benefit White students. Thus, in fighting against affirmative action, Asian Americans end up advocating for policies that hurt their own communities."
>
> *(C.J.C.)*

Collectively, we feel strongly about resisting the MMM to change the trajectory of how Asian Americans are racialized. To us, denouncing this myth is important because of the harm it causes to the Asian American community and to other communities of color in academic medicine. Considering the interracial solidarity that occurred during the Black Lives Matter movement and the Civil Rights movement in the 1960s and '70s where Black, Asian American, and Latinx communities came together in solidarity, we believe we can create more meaningful change in partnership with others.

We suggest several actions that can be taken to dismantle the MMM and its harmful effects,[1] included in Table 2.

We call on our colleagues to join us. Understanding the MMM and working to resist it is a first step toward understanding the experiences of Asian Americans in academic medicine. By working together to dispel the MMM, we take a step forward in antiracism and work toward a more authentically inclusive environment that recruits, retains, and promotes our increasingly diverse community.

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TABLE 1. How the Model Minority Myth Harms Asian Americans and Other Minoritized Groups

Theme	Illustrative quotes
Harms to Asian Americans	"As I have transitioned into my own practice, still in Utah, I have had multiple Mandarin patients who ask to not use a translator after hearing me introduce myself in their native tongue. However, I feel bitter that I still need to depend on a medical translator because my program did not allow me the resources or dedicated time to learn medical Mandarin, even though those same opportunities were offered to residents to learn medical Spanish." (J.L.) "I did not know then why [being referred to as a model minority] angered me so much given that the individuals did not mean any harm. . . . I think back and feel that my anger might have been centered on their subversion of my identity and rejection of the model." (D.R.)
Harms to other minoritized groups	"Many teachers have shared what they thought was with good intentions how I embodied the model minority myth: what a good student I was for doing what was asked of me. If only the 'other' students obeyed as well; 'other' meaning the other minorities at my school, particularly Hispanic and Black students. These instances made me realize how damaging the model minority myth was. Not only was my performance and demeanor pitted against other People of Color, but these comments also made me realize I was also seen as the 'other.' Though I was born in this country and have not known any other place as home, I still did not feel that I belonged." (J.L.) "In high school, the students all around me in the AP classes embodied the model minority. At least half of the class came had parents who emigrated from an Asian country (mostly China, Taiwan, Korea, Vietnam), and at graduation the majority had plans to start college at a University of California campus or Ivy League college. It was rare to think anyone would go to a community college. However, looking back, those were the students who needed the most help but were overlooked. Just because their parents were from Asia, it didn't mean the math and sciences would come naturally to them. The high school counselors neglected to detect such struggles as they focused their attention on other failing students. This pattern of disregarding the resources individuals may need solely based on their ethnicity continued throughout medical school. I recall one very brash surgeon who would stereotype every Asian female who rotated with him as someone interested in ophthalmology or dermatology. He didn't think any one of us would ever consider orthopedics, neurosurgery, or any 'tough' specialty." (T.F.H.)
Exclusion from retention and recruitment efforts	"When I matriculated into our family medicine program, it was touted how we were the most diverse class the program ever matched. This only included two of us Asian Americans out of 10 residents, both with different ethnic backgrounds, family history, and stories to achieving our medical degrees. Having two Asian Americans seemed to check a box, where efforts could be invested in recruiting other residents of diverse backgrounds. Yet, we struggled feeling known or valued by our department where faculty could not decipher between our names, let alone our different backgrounds and journey to medicine. While we both served as chief residents, there did not seem to be significant effort to try and retain us as faculty. Neither of us took a job at our program and now practice elsewhere." (J.L.) "It didn't take long to notice cracks—not in my patients or my work, but in the organization itself. The lack of diversity became glaringly obvious, especially as I often found myself as the only Asian American physician in the room. When I raised concerns about recruiting and retaining a more diverse workforce, leadership dismissed them with platitudes such as 'We hire the best candidates' or insisted diversity was already present—statements that didn't match the reality I saw. Over time, it became clear the organization was uninterested in retaining people like me. Departing colleagues were met with indifference, as if we were all replaceable. We were told that 'the grass isn't greener.' My attempts to spark meaningful conversations about diversity, equity, and inclusion were met with defensiveness and a refusal to acknowledge problems. This indifference, coupled with a lack of mentorship and belonging, made it impossible to stay. I loved my patients and believed in the work I was doing, but I couldn't remain in a place unwilling to see me—not just as a physician, but as a person. Leaving was difficult, but it taught me a vital lesson: Organizations that neglect diversity and inclusion fail not only their employees but also their patients and communities." (M.K.C.)

TABLE 2. Suggested Interventions for How Family Medicine Faculty Can Mitigate MMM Harms

Intervention area	Action item
Education	Learn about Asian American history and how Asian Americans are racialized in the United States. Acknowledging how the MMM is harmful, the kinds of racism Asian Americans face, and their liminal position may go a long way in making Asian Americans in medicine feel understood. Understanding the forms of discrimination that Asian Americans face can also prevent faculty and staff from being the ones to commit microaggressions and perpetuate harm. Recognize how the experiences of Asian ethnic subgroups differ and how such historical context impacts their sociopolitical attitudes and perspectives.
Recruitment	Disaggregate data whenever possible. Aggregated data hides the differential achievement of Asian Americans and gives the appearance that targeted recruitment efforts do not need to focus on any Asian Americans, when in fact some Asian ethnic groups are underrepresented in medicine. When designing recruitment events targeted toward minoritized populations, include Asian Americans in planning efforts and as institutional representatives while being mindful of the minority tax.
Retention	Include Asian Americans in conversations about health equity, because their unique perspectives will lend much to such conversations. Asian Americans have unique experiences that can provide effective and positive changes in academic medicine culture, particularly in family medicine. Take care not to view recruiting Asian Americans as an endpoint, but as a beginning to ensure that their presence is not just for representation purposes.
Promotion	Mentor Asian American trainees and faculty through the promotion process and into leadership positions.

Abbreviation: MMM, model minority myth