

CARDIOVASCULAR MEDICINE AND SOCIETY

How Do Asians Fit Into the American College of Cardiology's Diversity and Inclusion Initiative?



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The American College of Cardiology (ACC), a nonprofit medical association, is intricately involved in shaping the cardiology workforce. Because training physicians is funded largely by the federal government of the United States, the ACC has the responsibility to assist in the use of these funds to ensure that the workforce is best suited to meet the health care needs of a populous and diverse nation. Since early 2017, the ACC Task Force on Diversity and Inclusion has worked to address some of these challenges (1,2).

The 4 racial and ethnic groups considered in the task force analysis were white, Hispanic, African American, and Asian (1). The 3 nonwhite groups, each representing <20% of the U.S. population, are generally considered minorities. A major task force objective is to promote the interests of “underrepresented” minorities in the cardiology workforce, specifically Hispanics and African Americans. Despite being the smallest of the 3 minority groups in the United States, Asians (or Asians/Pacific Islanders) were largely unaddressed. Herein is a perspective on task force proposals with an emphasis on how they may affect Asians. Of note, people of Middle Eastern origin are considered white by the Census Bureau and, for consistency, will be so here as well.

DEFINING DIVERSITY

Diversity of a subgroup drawn from a national population, such as the cardiology workforce, lacks a consensus definition. The ACC Task Force on Diversity and Inclusion asserted that “cardiology is not

a diverse profession” (1). The ACC Diversity and Inclusion Initiative defined underrepresented cardiovascular providers as “a significantly lower proportion of members and/or leaders, relative to the U.S. population and/or relative to the available source population (including parent specialty/residency program)” (2), but only the definition referenced to the U.S. population has been used to define diversity elsewhere (1,3). Therefore, the only commonly referenced racial and ethnic minority groups that counted were Hispanics and African Americans (1).

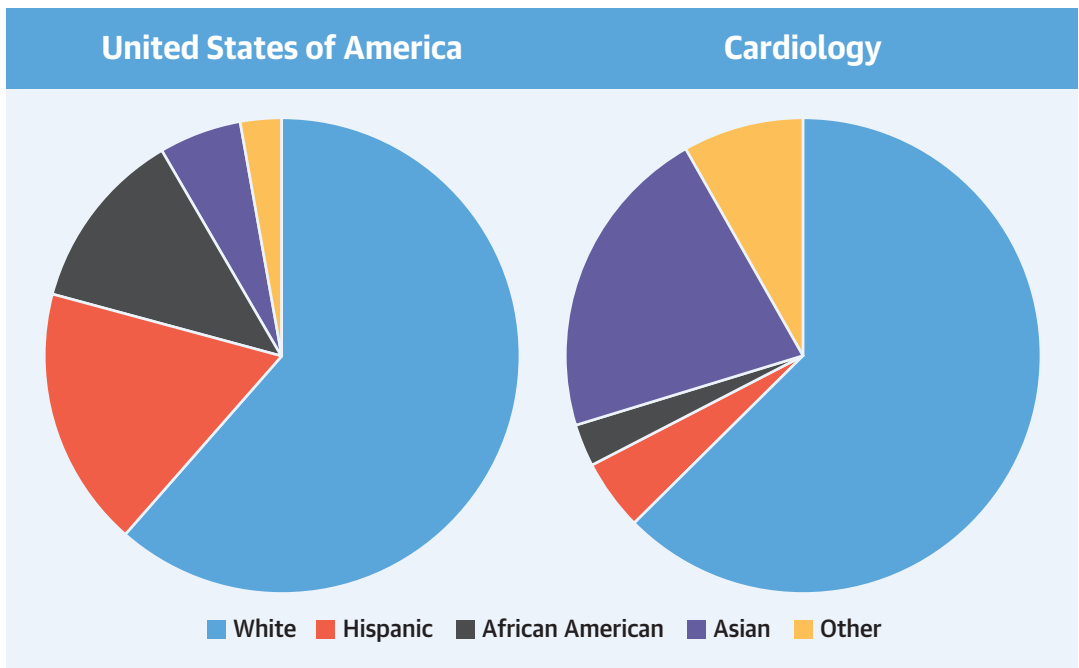
One strategic initiative of the task force is to “ensure the entry and advancement of...under-represented minorities in the field of cardiology” (1). More recently, it was stated that “each [ACC state] chapter will be provided its membership composition by... race” as a means for “accountable execution” (3). A reasonable conclusion, given these features and terminologies, is that a long-term objective is to design a cardiology workforce and leadership that mirrors the U.S. population. This is a strategy of demographic balancing known as proportional representation.

Under-represented minorities in the task force model, Hispanics and African Americans, accounted for 30.0% of the U.S. population but only 7.7% of the cardiology workforce (1). This yielded a diversity gap of 22.3%. Inexplicably, whites and Asians were combined. A more granular approach using the same reference for the cardiology workforce and the corresponding U.S. census from 2015 offers an alternative view (Figure 1) (4). Minorities, or nonwhite racial and ethnic groups, accounted for 38.4% of the U.S.

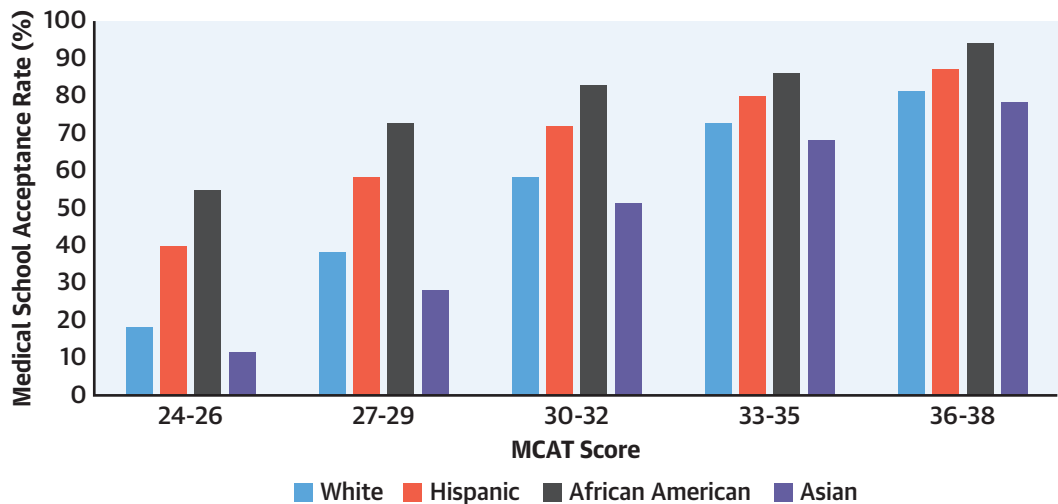
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FIGURE 1 Racial and Ethnic Data



p < 0.05 for Asian Versus Other Racial/Ethnic Groups Individually in Every MCAT Score Group



(Top) U.S. population composition in 2015 from census data: white, 61.6%; Hispanic, 17.6%; African American, 12.4%; Asian (Asian/Pacific Islander), 5.6%; and other (American Indian and 2 or more races reported), 2.8%. Cardiology workforce composition in 2015 from Lewis et al. (4): white, 62.7%; Hispanic, 4.8%; African American, 2.9%; Asian (Asian/Pacific Islander), 21.3%; other (other and not reported), 8.3%. **(Bottom)** Medical school acceptance rates by racial and ethnic group and Medical School Admission Test (MCAT) score group from 2013-2014 to 2015-2016 (aggregated) (adapted from Association of American Medical Colleges [8]). In every MCAT score group, Asian race or ethnicity was associated with lower medical school acceptance rates compared with other groups individually (p < 0.05 for all comparisons).

population and 37.3% of the cardiology workforce, for a diversity gap of only 1.1%. Diversity, on the basis of nonwhite racial and ethnic minorities, is therefore comparable. The difference between models is due primarily to Asians, who were not included in the task force model, presumably because of “overrepresentation.”

DEFINING INCLUSION

Inclusion, likewise, lacks a consensus definition. Terms such as “equitable” and “welcoming” encapsulate the spirit of inclusion (1). In 2016, the percentage of Hispanic and African American medical school matriculants were 6.3% and 7.1%, respectively (5). These were not dramatically different from Hispanic and African American cardiology trainees, recently estimated at 6.8% and 5.4%, respectively (1). Therefore, the main limiting step for representation in cardiology is medical school admissions.

A more objective measure of inclusiveness in the medical profession is medical school acceptance rates as related to academic qualifications. Capers et al. (6) suggested that implicit bias may be a reason for the low prevalence of Hispanics and African Americans in medical schools. Negative bias leading to a lack of inclusiveness would therefore be present if acceptance rates were lower for one racial or ethnic group compared to others, despite similar academic qualifications.

The Medical College Admission Test (MCAT) is a standardized examination required for almost all medical school applicants. It is the most objective means to compare applicants. MCAT scores have a positive association with unimpeded progress toward graduation and are a stronger predictor than even undergraduate grade point averages (7). Acceptance rates are, in fact, the highest for Hispanics and African Americans in every MCAT score group (Figure 1) (8). MCAT scores are only one piece of applications, but these findings suggest that admissions are the most favorable to these racial and ethnic groups.

LIMITATIONS OF THE PROPORTIONAL REPRESENTATION MODEL

Proportional representation has never been demonstrated to be achievable in any profession in a large multiracial and multiethnic nation such as the United States. Certain demographic groups may simply have proclivities toward one profession over another. Prior studies have suggested that the presence of Hispanic and African American primary care physicians may be associated with greater access to care for vulnerable communities. Less certain are whether these findings

extend to cardiology and what is an appropriate “threshold of representation” target. Racial and ethnic compositions are also dynamic. If one day Hispanics and African Americans become “overrepresented” within cardiology, aspiring students and trainees of those backgrounds should still be strongly encouraged to pursue careers in cardiology.

Variability of educational and socioeconomic backgrounds within groups should be considered. “Asians” are heterogeneous. Data from the Migration Policy Institute in 2016 listed 124 countries with immigrants to the United States by educational attainment, specifically the percentage with a bachelor’s degree or higher (9). Nigeria was number 12 at 59.6%, Venezuela was number 23 at 54.8%, and Cambodia was number 114 at 14.3%. By the task force definition, a Nigerian American or a Venezuelan American would count toward diversity, but a Cambodian American would not. Yet there is no reason to believe that Cambodian Americans do not face similar or greater social and/or economic impediments. This would seem counter to inclusivity.

AN ASIAN DILEMMA?

Portraying Asian as equivalent to white in the ACC Task Force on Diversity and Inclusion model (1) perpetuates the model minority stereotype, ignores several realities, and treads on concerning territory. Medical school admissions are a zero-sum game. Efforts to achieve proportional representation for underrepresented groups will come primarily at the expense of Asians who are, by extension, viewed as overrepresented. Acosta et al. (5) demonstrated that almost all minority gains in medical school acceptances between 1980 and 2016 were among Asians. However, changes in applicants were markedly different between groups: –13% for whites, +87% for Hispanics, +73% for African Americans, and +564% for Asians (5)!

Asian race or ethnicity is associated with far lower rates of medical school acceptance compared with other racial and ethnic groups, even whites, in every MCAT score group (Figure 1). It raises the suspicion that implicit bias, if present, is most detrimental toward Asians. That the percentage of Asians in cardiology is relatively high should not discount the possibility of exclusionary tendencies and unofficial de facto quotas. In 1948, the New York State Legislature, attempting to correct discrimination resulting from Jewish quotas in medical schools that were based on proportional representation, stated, “the American ideal of opportunity requires that students, otherwise qualified, be admitted to educational

institutions without regard to race, color, religion, creed, or national origin” (10).

Being perceived as overrepresented may lead to fewer opportunities if institutions believe they have “too many Asians.” By combining white and Asian, the task force may overlook distinguishing characteristics. For example, the ACC was founded in 1949 but has never elected a president of Asian race or ethnicity. This is a missed opportunity, as those of Asian descent may more easily bridge cultural barriers to strengthen ties to economies and cardiology communities in Asia. Given the success of Asians in cardiology, more inclusion on the task force may provide additional insight on how best to create diversity programs.

THE PATH FORWARD

Increasing diversity and inclusion is conceptually a noble endeavor. The ACC Task Force on Diversity and Inclusion goal of “encouraging high school and college minority students to consider a career in medicine” (3) should additionally provide educational and research opportunities to raise objectively measured academic credentials. The absolute numbers of Hispanics and African Americans in cardiology are small, so those with enthusiasm and talent should have full support. It should be clear that the majority of resources should be directed toward increasing the number of qualified medical school applicants (5).

Social engineering to create proportional representation needs to be approached with caution. Equality of opportunity, even if present, does not necessarily lead to equality of outcome. Race and

ethnicity, if considered, should be examined in the entirety of what a person has to offer, not in isolation. Assessment of how task force proposals will affect Asians, who may already be negatively affected by implicit bias, should be explored in greater detail. In diversity calculations, Asians should be neither excluded because of “overrepresentation” nor portrayed as equivalent to whites.

In its essence, use of the proportional representation model for the cardiology workforce appears reductive. It is certainly possible that some physicians have tendencies to serve in areas with patients of their own race or ethnicity. However, exposure to underserved populations during medical training may inspire trainees of any background to choose to practice in such settings. Sincere devotion to practicing in underserved communities and/or conducting research to reduce racial/ethnic health care disparities should be among several factors considered in medical school admissions.

In the end, patients and others interact with individuals, not the collective characteristics of designated groups. Those of us in academic medicine owe it to our patients, who are our first responsibility, to select the most qualified individuals who will be passionately devoted to their care.

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REFERENCES

- Douglas PS, Williams KA, Walsh MN. Diversity matters. *J Am Coll Cardiol* 2017;70:1525-9.
- American College of Cardiology. Diversity and inclusion. Available at: <https://www.acc.org/about-acc/diversity-and-inclusion>. Accessed February 13, 2019.
- Douglas PS, Miller A, Khandelwal A. Improving diversity and inclusion in cardiology at the state level. *J Am Coll Cardiol* 2018;72:2265-8.
- Lewis SJ, Mehta LS, Douglas PS, et al. Changes in the professional lives of cardiologists over 2 decades. *J Am Coll Cardiol* 2017;69:452-62.
- Acosta DA, Poll-Hunter NI, Eliason J. Trends in racial and ethnic minority applicants and matriculants to U.S. medical schools 1980-2016. Available at: <https://www.aamc.org/download/484966/data/november2017trendsinfra>
- Association of American Medical Colleges. Table A-24: MCAT and GPA grid for applicants and acceptees by selected race and ethnicity 2013-2014 through 2015-2016 (aggregated). Available at: <https://www.aamc.org/data/facts/cialandethnminorityapplicantsandmatricu.pdf>. Accessed May 21, 2019.
- Capers Q IV, Clinchot D, McDougle L, Greenwald AG. Implicit racial bias in medical school admissions. *Acad Med* 2017;92:365-9.
- Dunleavy DM, Kroopnick MH, Dowd KW, Searcy CA, Zhao X. The predictive validity of the MCAT exam in relation to academic performance through medical school: a national cohort study of 2001-2004 matriculants. *Acad Med* 2013;88:666-71.
- Association of American Medical Colleges. Table A-24: MCAT and GPA grid for applicants and acceptees by selected race and ethnicity 2013-2014 through 2015-2016 (aggregated). Available at: <https://www.aamc.org/data/facts/applicantmatriculant/157998/factstablea24.html>. Accessed May 21, 2019.
- Migration Policy Institute. Frequently requested statistics on immigrants and immigration in the United States. February 8, 2018. Available at: <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states#Demographic>. Accessed May 21, 2019.
- Sokoloff L. The rise and decline of the Jewish quota in medical school admissions. *Bull N Y Acad Med* 1992;68:497-518.

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