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Kailynn J. Yang, Danielle G. Iben

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The Paradox of Visibility Among Asian American Medical Students: A Personal Reflection

Kailynn J. Yang BS¹, Danielle G. Iben BS¹

¹Loyola University of Chicago Stritch School of Medicine, Maywood, IL, USA

Corresponding author:

Kailynn J. Yang

Email: kyang4@luc.edu

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10 1. Abstract

11 During the pandemic, anti-Asian discrimination increased substantially, with over 80% of Asian
12 Americans reporting experiences of everyday discrimination. Within medical training environments,
13 Asian American students continue to experience racial microaggressions, including ethnic
14 misidentification and stereotyping, reported by nearly 70% of trainees. Cultural stigma surrounding
15 mental health and the persistence of the model-minority myth further contribute to low utilization of
16 mental health services and exclusion from institutional diversity initiatives. Collectively, these factors
17 reinforce a paradox of visibility and invisibility among Asian American medical students that adversely
18 affects well-being and belonging. Addressing these challenges requires intentional institutional action,
19 including the integration of longitudinal reflective practice programs in medical curriculum, incorporation
20 of structured reflective dialogue through case-discussions, enhanced bystander intervention training
21 during clerkship orientations, expanded access to culturally responsive mental health care, and sustained
22 support for identity-focused spaces. Such efforts are particularly critical in the current sociopolitical
23 climate, where initiatives to advance diversity and inclusion in higher education face increasing
24 challenges. This perspective examines this paradox through personal reflection alongside evidence-based
25 literature on the Asian American medical student experience during and after COVID-19. Our
26 perspectives are informed not only by our shared racial identity, but also by our lived experiences
27 navigating medical education post-pandemic.

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30 2. Manuscript

31 As Asian American medical students who entered our medical training in the Fall of 2022, the height of
32 the COVID-19 pandemic had already passed. Vaccines were available, masks were optional, and
33 institutions were eager to move forward. Yet for many Asian Americans, the effects of that period
34 lingered quietly and were carried into classrooms, clinics, and conversations, largely unspoken.

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36 During the early months of the pandemic, anti-Asian sentiment surged across the United States. More
37 than 80% of Asian Americans reported experiencing discrimination in everyday life, and nearly one-third
38 screened positive for anxiety or depressive disorders.¹ In 2020, anti-Asian hate crimes increased by 145%
39 despite an overall decline in hate crimes.² The pandemic resulted in the racialization of disease and
40 reinforced existing stereotypes of Asian Americans, resulting in increased discrimination and social
41 exclusion.³ Like many others, we felt that these stories of violence and fear were simultaneously distant
42 and deeply personal.

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44 We entered medical school hoping medicine would be different. In a profession shaped by science,
45 compassion, and integrity, we believed that the color of our skin would matter less – that we would be
46 recognized as equals among peers who had all worked tirelessly to enter the ivory tower of medicine. We
47 imagined medicine as a refuge, insulated from the discrimination we faced in the outside world. Instead,
48 we encountered a more subtle form of erasure.

49

50 During clinical rotations, we were often confused for other Asian classmates by both resident and
51 attending physicians. Initially, we offered corrections in the hope of being recognized as individuals. Over
52 time, however, the repetition of being misidentified for the third, fourth, or fifth time, proved exhausting.
53 Patients, peers, and faculty also assumed our ethnicity with confidence, rarely pausing to ask. At our VA
54 Medical Center, these assumptions surfaced in the form of soliciting remarks rooted in racial and

gendered stereotypes, reflecting the complexity of navigating intersecting identities. Remarks such as, “I dated someone who looked like you,” or “My wife is from X Asian country,” were often framed as casual or even friendly. Yet they remind us that we are seen interchangeably, despite the immense diversity within Asian American communities, which encompass more than 50 ethnic groups across over 20 countries, each with distinct cultures, practices, and histories.⁴

This sense of interchangeability extended into classrooms, where peers and faculty would confidently confuse us for one another, overlooking our individual identities. In group settings, we were at times dismissed or talked over, shaped by stereotypes that portray Asian students as quiet, passive, or submissive.

Our experiences are not exceptional. Post-pandemic, nearly 70% of Asian American medical students report experiencing racial microaggressions during their training, most commonly from patients (70.9%), peers (59.2%), and faculty (42.3%).⁵ Rarely overt or malicious, these interactions accumulate quietly, shaping a sense of being present but unseen.

Ultimately, what we see is a paradox of visibility among Asian American medical students that predates, but has been intensified by the COVID-19 pandemic. On one hand, we are visible in the sense that we are well represented in medical education and comprise approximately 25% of matriculating U.S. MD medical students.⁶ We are also often perceived through the lens of the “model-minority” stereotype, characterized as having achieved success in American society. On the other hand, being seen this way also makes us invisible. Assumptions of having achieved equality dismisses the challenges we face in medicine, along with the weight of our unique struggles and experiences. Despite our presence in medicine, we are often excluded from institutional diversity efforts, operating under the assumption that representation alone equates to equity.⁷ The model-minority myth persists quietly, masking vulnerability

and reinforcing the belief that Asian American students do not require support. Recent qualitative research further highlights this paradox, with Asian American medical students describing feeling visible within medical institutions while simultaneously a target of anti-Asian racism post pandemic.⁸

The psychological weight of this invisibility is compounded by cultural norms many of us were raised with. In our families, mental health was not discussed openly. Distress was something to endure privately. Like many children of immigrants, we grew up hearing stories of survival from parents and grandparents who escaped war, political instability, or economic hardship. Their resilience became an implicit expectation: if they could endure everything they had faced, surely, we could endure anything as well.

Within many Asian cultures, mental illness continues to be associated with weakness or moral failure. As a result, Asian Americans are among the least likely racial groups to seek mental health care. Fewer than 9% access services annually, compared to 18% of the general U.S. population.⁹

For us, finding community through the Asian Pacific American Medical Student Association (APAMSA) shifted this narrative. Within this space, we connected with peers who understood the tension of being simultaneously visible yet invisible. These relationships validated our experiences and highlighted the importance of community in navigating medical training. Through outreach and advocacy, we learned that narratives can transform isolation into solidarity.

Addressing this paradox is particularly urgent in the current sociopolitical climate, where efforts to advance diversity and inclusion in higher education face increasing challenges, and where anti-Asian racism persists in the post-COVID era. For example, in March 2024, a bill introduced in Congress proposed prohibiting medical schools from receiving federal funding if they implement diversity, equity,

and inclusion (DEI)-related policies or requirements, despite recommendations from major medical organizations to incorporate implicit bias training into medical education.¹⁰

Responding to this paradox requires a sustained institutional commitment to equity and actionable change. Within the classroom, medical curricula should explicitly incorporate training on racial microaggressions that includes Asian American experiences, which are often overlooked in discussions of race.¹¹ Case-based learning with facilitated discussions can help both students and faculty recognize how seemingly benign interactions such as misidentification or assumptions of ethnicity can contribute to harm. Several institutions have already implemented their own longitudinal reflective practice programs as part of professional identity formation (PIF) curricula to address race, bias, and microaggressions. For example, Stanford University School of Medicine developed the “5-Minute Moment for Racial Justice,” a longitudinal, case-based curriculum designed to normalize discussions of racism in medicine. Similarly, the University of Pittsburgh Medical Center developed the FOREM (FORging Equity in Medicine) curriculum to equip learners with strategies to address racism, mitigate implicit bias, and apply anti-racist practices in clinical environments.¹²

In clinical training settings, clerkship leadership should implement structured reporting pathways and bystander intervention training to equip students with practical strategies to respond to biased comments from patients, peers, and physicians. Evidence from a recent rapid review suggests that even brief, skills-based bias response intervention training can improve confidence and frequency of speaking up in clinical settings.¹⁰

Given the persistently low utilization of mental health services among Asian American populations, institutions should also expand access to culturally responsive mental health care. This includes recruiting

128 diverse counseling staff who understand the historical and generational contexts shaping Asian American
129 experiences, as well as training faculty to practice with cultural humility.

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131 Finally, institutions should actively support identity-focused spaces such as APAMSA. In the current
132 sociopolitical climate, these spaces are sometimes characterized as exclusionary towards the broader
133 goals of inclusion; however, our experiences suggest the opposite. Rather than fragmenting communities,
134 identity-focused foster connection by providing supportive environments in which students can process
135 shared experiences, develop leadership skills, and build confidence to engage more fully in the broader
136 medical community. We believe it is important to recognize that these spaces are not mechanisms of
137 separation, but are essential sources of support in environments where students may otherwise feel
138 unseen.

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140 Ultimately, the paradox of visibility and invisibility continues to shape the Asian American medical
141 student experience. Although we are well represented in medical education, the challenges we face,
142 intensified by the COVID-19 pandemic, often remain unnoticed. Recognizing this paradox exists is a
143 critical first step toward addressing structural and racial bias within medical education and advancing
144 equity across classroom, clinical, and institutional settings.

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