

ETHICS CASE

Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds

Commentary by Barret Michalec, PhD, Maria Athina (Tina) Martimianakis, PhD, Jon C. Tilburt, MD, MPH, and Frederic W. Hafferty, PhD

Abstract

In this case we meet Amanda, a medical student of Native and Latin American ethnicity who receives financial aid. Her friends are surprised by her interest in an elite residency program. They suggest, rather, that with her language skills, ethnic background, and interest in social justice, she has a responsibility to work with underserved patient populations. In our commentary, we consider issues raised by the case and explore Amanda's friends' underlying expectations and assumptions that perpetuate the very inequities that the resolution of the case purports to address. We also identify the role of privilege and address the "burden of expectation" that appears to be associated with underrepresented minority (URM) medical students and normative assumptions about their career paths.

Case

Amanda is a second-year medical student at a private Midwestern medical school, which she is able to attend thanks to an institutional scholarship and federal financial aid. She has been seriously engaged with campaigns on campus for health equity and social justice in the community and in the country at large. Amanda grew up in a family with mixed Native American and Latin American roots and was a first-generation college graduate in her family; thus, issues of access to education and health care are very important to her.

Amanda grew up speaking Spanish fluently and studied medical Chinese in her first year of medical school. She has used her language skills in a medical student-run clinic that provides free basic clinical services to those with limited English proficiency (LEP), which includes Spanish and Chinese speakers. As a second-year medical student, she has begun thinking about clinical years and plans for a successful residency match. During her recent visit with her family over Christmas, her parents and maternal grandmother

expressed their pride in her accomplishments and their desire that she match into a competitive specialty and residency program.

At school, she is having a discussion with friends about their current career interests. When she expresses her anxieties about what it takes to match into a competitive specialty in an elite residency program, her friends express surprise. “I thought since you were so passionate about social justice, you’d be more interested in working with minority populations back home.” Others concur and express the opinion that, as someone with the cultural competencies and language skills to work with immigrants in her home state, she has a responsibility to utilize her skills for LEP populations. She wonders what to say.

Commentary

Talk of “ethical dilemmas” diverts attention from the structural conditions that have produced the problem in the first place.

Daniel Chambliss [1]

As a team of three social scientists and a physician bioethicist—and following De Vries’ [2] distinction between sociologists *in* medical ethics (e.g., functioning as “collaborators”) and sociologists *of* medical ethics (e.g., functioning as “outsiders” and “debunkers”)—we will problematize as well as address issues raised by the case. In both respects, we pay special attention to the concept of *expectations*, exploring where expectations about “paying back” may originate along with the impact these expectations may have on (medical) career pathways and professional identities. Within this discussion, we introduce the concept *burden of expectation* in exploring the assumed responsibility of underrepresented minority (URM) students regarding specialty choice, type of practice, patient population, and practice location.

How Ethical Is the Ethical Dilemma?

The opening paragraph of this case is a sociological smorgasbord. Nested within the case are not only tacit messages suggesting privilege for some and obligation for others but also assumptions associated with typical gender norms; ethnicity biases; medical students’ socialization and professional development (most notably in regards to career expectations); and explicit, implicit, and even hidden institutional-level barriers and hurdles for URM students. However, the lightning rod in Amanda’s case is text specifying that she is able to attend medical school “thanks to an institutional scholarship and federal financial aid.” We will begin our comments, therefore, by discussing the (explicit and implicit) institutional and societal expectations that can be associated with this kind of support for students, specifically those who are members of underrepresented minority groups.

The language of the case itself depicts Amanda as a subordinate and essentially indebted social actor. An explicit and contractual agreement with a financial institution to repay a monetary loan seems now to have been stretched by others to include a more implicit expectation that she go into a particular field or specialty and focus her studies, training, and skills on certain geographic areas or patient populations, thus metaphorically continuing to pay back her debt as an “indentured” activist: one whose debt can only be repaid by meeting gender- and/or ethnicity-specific *de facto* service requirements.

Furthermore, the above case implicitly positions (and quite favorably) the medical school as a neutral bystander (or perhaps even a benefactor) in this relationship. This case obviates the fact that Amanda’s type of scholarship also helps lure or retain URM applicants—which, in turn, improves the rankings of the school, including its diversity profile and identity as a socially responsible institution. Helping students from URM groups attend medical school raises the reputation of the university at a time when there are growing social responsibility expectations of all higher education institutions. Furthermore, support programs exist such as institutional scholarships, separate admissions tracks for those interested in rural medicine or nontraditional majors, and even loan-repayment programs funded through the Affordable Care Act that recruit medical students to work as primary care clinicians in underserved areas, with varying service commitments [3]. In turn, these programs’ expectations as well as gender- and ethnicity-related assumptions can restrain students’ (especially URM students’) self-determination and agency, possibly pushing them down professional pathways other than those the students originally envisioned.

The Fortitude of Expectations

Our theme of how expectations may limit self-determination continues as we consider how the case characterizes Amanda’s friends. In directing our attention to a micro issue (i.e., Amanda struggling with “what to say” to her friends), the structure of the case itself diverts our attention from much larger, meso (institutional) and macro (sociocultural) issues. We read that Amanda’s friends are surprised by her desire to pursue a competitive specialty, as they express their expectation that she would return home and pursue a route more directly tied to working with underserved patients given her interest in social justice, her language skills, and her apparent competence in various cultures. What is important (ethically) here is that these expectations reflect and express implicit biases [4, 5]—subconscious stereotypes—that are cultivated through [socialization processes](#) (including those associated with medical professional development) that guide beliefs, perceptions, and even interactions. A prominent theoretical stance in the sociology literature known as the conflict perspective suggests that socialization represents a powerful means of social control because people are implicitly and explicitly taught norms, values, and perspectives that reflect the hegemony of those in positions of power and authority [6]. Therefore, through more systems-level socialization

processes (e.g., education, family, peers, media, faith-oriented), and through socialization processes and mechanisms nested within and associated with the institution of medicine specifically, trainees internalize the values, beliefs, and practices of their profession—for better or for worse—and perpetuate them through their own actions, beliefs, and assumptions. Socialization processes often unfold without the learner necessarily being aware of their impact and influence or reflecting upon how things are versus how things *should* or *could* be. As a result, ethically problematic assumptions and expectations about colleagues' backgrounds and callings can arise and persist over time.

Within this case specifically, expectations held by Amanda's friends reflect a set of particular overarching societal-level stereotypes that linger within medicine and its educational culture: (a) women *should* desire work in more patient-centered specialties and (b) ethnic minorities, if given opportunities through education and/or employment, *should* "pay it forward" (through particular career paths) [7, 8]. These stereotypes underpin the ethical dilemma. Amanda is portrayed as deviating from the norm when she dares to consider a career that does not involve working with URM patient groups. The reaction of her friends who expect that Amanda would want to go this particular professional route as well as the framing of these expectations as "responsibilities" acts as a powerful reproduction, a safeguarding of sorts, of the norm's power over Amanda and what she *could* do and be in the world.

Assumptions and Expectations (or Lack Thereof) Associated with Privilege

Consistent with these implicit biases about women and ethnic minorities and their potentially limiting impact on these groups' professional options, Amanda's friends (and others) apparently believe that because of her ethnic background and language skills, Amanda has a responsibility to serve a patient population of similar ethnic and linguistic background. This expectation is supported by Amanda's purported avowed and embodied interest in issues of access to education and health care. It also reflects the protective shroud of privilege—[social advantages](#) (often race or ethnicity and gender) that protect certain people and provide a more clearly paved path to upward social mobility in comparison to others who encounter explicit and implicit hurdles and pitfalls (e.g., institutionalized sexism and racism).

In this case, Amanda's friends' privilege is reflected in their apparent assumption that they do not have responsibility to work with underserved patient populations and that they somehow see themselves as more free than Amanda to explore their own professional interests. Furthermore, they hold this assumption despite the fact that medicine, foundationally, is a service profession and that all medical professionals have a fiduciary responsibility to serve diverse patient populations. In contrast to her friends, Amanda is attributed a burden of service because of her ethnic identity, language skills, and having previously worked to alleviate health inequities.

From her friends' viewpoint, Amanda's skills stemming in part from her ethnicity make her more *naturally* suited for work in URM communities. Thus, whereas Amanda is chained to an expectation of altruistic medical "servitude," her friends (note the text does not say that they expect Amanda to *join them* in service to minority, immigrant, and LEP patients) are protected from this mantle of responsibility because of their privilege.

Students who are members of URM groups are indeed more likely to practice in underserved areas and work with disadvantaged patient populations. As Bennett, Phillips, and Teevan [9] noted in an earlier issue of this journal, "students with rural backgrounds are much more likely to practice in rural settings, and African American students more often choose inner-city practice. ... Women ... disproportionately choose primary care." In turn, the authors articulate support for premedical pipeline programs that encourage students from disadvantaged and minority groups to enter the medical profession: "because these students are more likely to work with underserved populations after graduation, increasing their interest in health professions and investing in academic support may help correct the current physician maldistribution."

In this quotation, once again, we encounter evidence for connecting the admission of URM students to implicit expectations that these students work in underserved areas. This is emblematic of the very same set of biasing assumptions that are shared among Amanda's friends, particularly since the authors of the quoted source provide no evidence about why these students "choose" to work with these particular patient populations. These same assumptions can impact admissions and recruitment strategies—which can be reflected in financial aid and scholarship offerings and eventually become nested within institutional culture and practice as they become reinforced through faculty-student and student-peer interactions.

The Fairness of Expectations

We were tasked with the following question in relation to the case: "Which criteria should be used to assess the fairness of expecting location-specific, language-specific, or population-specific service from students or graduates from underrepresented minority or low-income backgrounds?"

We believe it is fundamentally unfair to differentially *expect* URM students—because of their underrepresented, disadvantaged, or underprivileged minority status—to work in underserved areas or with specific populations. Likewise, as we have argued, we believe it is unfair to *expect* these students to follow this specific professional track because they are assumed to be better prepared for it because of their ethnicity, cultural practices, or language skills. Moreover, such biases have created a burden of expectation that, when left unchallenged, can become institutionalized and limit the capacity of URM students to imagine or pursue upward mobility. This burden of expectations, which disproportionately falls on the shoulders of URM medical students, reflects a corruption

of the adage, "To whom much is given, much is expected." Rather, when discussing any "criteria" that should be used to assess fairness of expecting medical students to serve, we suggest that medical education institutions pose the following question to *all* of their community members, "If not me, then who?"

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