Achieving Latino Equity in Medicine, Nursing, and Dentistry Education: Accelerating the Path Forward

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Health professions are increasingly acknowledging legacies of racial/ethnic prejudice, discrimination, and exclusion. These legacies stem from institutional or sectoral policies, regulations, procedures, and behaviors that create and mutually reinforce disadvantage and inequity for racial and ethnic minorities (systemic racism) (Bailey et al., 2017). Institutions and professions in medicine and health care are actively examining the impact of racial/ethnic inequity in these domains (Hahn et al., 2018; IOM, 2003). A key aspect of such inequities is the historical underrepresentation of some minority groups in health care professions. Underrepresented minorities (URM) include those who identify as African American or Black, American Indian, Alaska Native, Latino or Hispanic, Native Hawaiian, and other Pacific Islanders (NIH, n.d.). Such underrepresentation negatively affects the quality, education, and cultural competence of the future health care workforce (LaVeist and Pierre, 2014; Phillips and Malone, 2014). It also contributes to the shortage of URM health care professionals, who disproportionately practice in communities with health care professional shortages, care for more patients from their own racial or ethnic group, and consistently receive higher satisfaction ratings and outcomes among underserved communities (LaVeist and Pierre, 2014; Weissman et al., 2001; Komaromy et al., 1996). These deficiencies in the health care workforce pose a significant threat to addressing health disparities and the health system’s ability to care for the Latino population and other URM individuals, especially given their significant projected growth in the U.S. population (Vespa et al., 2020; The Sullivan Commission, 2016).

Remediation efforts to rectify inequities in representation of URM health professionals should address the experiences and degree of disparity for each group. This manuscript aims to provide greater insight into Latino underrepresentation in medicine, nursing, and dentistry and to describe an approach for accelerating change in Latino underrepresentation in these three professions.

Minimal Progress

Recently, Ramirez et al. (2021) addressed the need to eliminate disparities in medicine for those who identify as Latino, or culturally heterogeneous people in the U.S. with ethnic heritage from the Caribbean, Mexico, Central and South America, and Spanish-speaking countries worldwide. In 2020, those who identify as Latino comprised 19% (62 million) of the U.S. population—larger than all other URM groups combined (58 million) (Lopez et al., 2021; United States Census Bureau, 2021). Between 2010 and 2020, Latino population growth accounted for 51% of the U.S. population increase, and this population is projected to increase to 128 million by 2050, then comprising 29% of the U.S. population (Krogstad, 2020; Passel and Cohn, 2008).

Data from professional associations in medicine (allopathic and osteopathic), nursing, and dentistry provide deeper insight into recent trends of Latino representation. Progress in increasing representation to reflect the U.S. Latino population is slow. From 2016 to 2020, those who identify as Latino represented 10% to 11% of applicants, 8% to 10% of enrollees, and 5% to 6% of graduates in allopathic medical schools (AAMC, n.d.). Osteopathic medical school trends from 2016 to 2020 show similar proportions of Latino applicants (8% to 10%) as allopathic medical schools but lower proportions of enrollees (5% to 7%) and graduates (4% to 5%) (AACOM, n.d.). In nursing, only enrollment data on race and ethnicity are available and indicate significant inequity and minimal Latino growth from 2016 to 2020 for both master’s (8% to 10%) and doctoral degrees (5% to 8%) (AACN, n.d.). In contrast, enrollment of those who identify as Latino at the bachelor’s level is higher, but with minimal growth in enrollment (12%
to 14%). Finally, Latino inequity in dentistry parallels that in medicine (ADA, n.d.). The proportion of Latino applicants to U.S. dental schools was unchanged between 2016 and 2020 (9%) and similar to the medical profession (8% to 10%) (ADEA, 2018; ADA, n.d.). Enrollment in dental colleges (8% to 10%) was similar to allopathic medical colleges (8% to 10%), but higher than in osteopathic medical colleges (5% to 7%) (ADA, n.d.). As a result, the proportion of Latino dental graduates (7% to 9%) for the 2016 to 2020 period exceeded that in medicine overall (5% to 6%). It is not surprising, therefore, that only 4% of medical school leaders and 2% of hospital leaders are Latino (Ramírez et al., 2021).

Systemic Causes and Invisibility

The significant underrepresentation of those who identify as Latino in these three health professions results from systems dynamics involving multiple components, defined as subsystems in complex systems science (Sternman, 2003). The subsystems include not simply the educational pathway for careers in these professions (K–12, colleges, professional schools) but also social, economic, and environmental subsystems affecting family life, school versus employment demands, mobility, educational achievement, access, and affordability. Effective long-term and sustainable changes that alter the systems dynamics to produce an overall outcome of equity for Latino individuals and other URM in medicine, nursing, and dentistry are needed. Although subsystems outside of education in medicine, nursing, and dentistry are contributing factors to Latino equity, they are beyond the scope of this commentary. Instead, the authors focus on changes in the medical, nursing, and dentistry education subsystems, which can help produce improved outcomes. The authors ask: How can these changes be approached in these professions?

Substantive change in the three professions and their institutions and actors, such as health education and research grant makers and funders, can be achieved through a rigorous systematic approach. This requires movement beyond missions and diversity statements—but also a commitment to examining, improving, and reengineering diversity missions, leadership, data, metrics, accountability for outcomes, resources, partnerships, communications, engagement, and related policies and processes. Although these strategies are not unique to improving Latino equity, the authors present a few considerations that are likely to significantly impact Latino equity. For example, equity missions must include clear outcomes, quantitative targets, and explicit timelines for achieving them, and institutional leadership must be held accountable for failing to meet these objectives.

Inequities in Latino representation in medicine, nursing, and dentistry, coupled with Latino invisibility in the scientific literature and public discourse, are shocking, given that the Latino population is the largest minority group in the United States. Throughout U.S. history and today, the Latino population has been subjected to anti-Latino and anti-immigrant policies, stigma, discrimination, and racism—including in health care and education (Amaro and Prado, 2021; Findling et al., 2019; Zambrana, 2018; Zambrana and Hurtado, 2015; Vasquez, 2013; Lopez et al., 2010). Gross inattention to Latino inequities in health care professions and education continues to render the Latino population invisible, even among intentional plans to advance URM diversity and representation. Contributing to this invisibility is the prevailing national focus on Black–White inequities in the United States, referred to as the Black–White binary paradigm of race (Gonzalez-Sobrino and Goss, 2019; Alcoff, 2003). This paradigm leads to an incomplete understanding of the role of inequities and racism affecting other URM groups and renders their histories and disparities invisible (Amaro and Prado, 2021). Thus, systems change to address the underrepresentation of the Latino population in the three identified health professions must start with giving visibility to this disparity and lifting up the history and the effects of systemic racism, discrimination, and colonization on the Latino population.

Remediation Approaches for Medicine, Nursing, and Dentistry

Health education schools should consider promising approaches to increase the number of Latino individuals in medicine, nursing, and dentistry. One promising approach is building strong pipelines from community college, to baccalaureate, and then to graduate education. For example, in nursing, models have been implemented to accelerate the proportion of registered nurses who complete baccalaureate or master's programs. These models have been implemented in more than 30 states and include accelerated options for a master's degree in nursing for associate degree graduates, regionally or state-shared curricula, and outcomes-based curricula (Campaign for Action, n.d.). Another approach to increasing diversity in applicant pools could be eliminating standardized tests, which
can discourage application, and employing a more holistic approach in applicant evaluation for admission (AACN, 2020).

Accountability for achieving Latino and other URM equity must also be required from governing bodies of health education entities (e.g., boards of directors); entities that represent the profession (e.g., honorific and professional organizations); entities that financially support health education (e.g., government agencies and foundations); and entities accountable for evaluating adherence to quality standards in medical, nursing, and dentistry education (e.g., certifying agencies). These entities are essential components of the health profession subsystem because they influence and enable the existence and functioning of health education. As such, they affect Latino and other URM equity by their actions or inaction.

Honorific professional organizations should publicly disclose and remediate URM membership underrepresentation. Grantmaking and funding organizations should adjust their decision-making processes both to prioritize funding for institutions that are achieving prespecified URM equity objectives and to substantially increase financial and program support for URM students in these fields to reduce attrition that may be due to educational debt burdens. Boards of trustees must ensure that URM equity targets and timelines are in place and replace leaders who do not meet these performance objectives. Finally, certification bodies in medicine, nursing, and dentistry can promote Latino and all URM equity by including URM representation targets and timelines as a component of institutional or program certification.

Eliminating Latino and other URM inequity in medicine, nursing, and dentistry is complex and requires implementing a rigorous approach that extends from quantitative goals and timelines to management and board accountability to communication and transparent public disclosure. Critically, it requires that organizations and their leaders understand the historical and contemporary biases that render the Latino population invisible and take steps to include them in the forefront of the inequity discourse. These steps can accelerate rates of change and move these health professions toward equitable URM representation.

References


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