IMPROVEMENT NEEDED IN LATINA PHYSICIAN REPRESENTATION: IMPLICATIONS FOR MEDICAL EDUCATION, TRAINING, AND POLICY

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EXECUTIVE SUMMARY

Diversity in the physician workforce can help build health equity for increasingly diverse and multiracial populations, yet the shortage of Latina/o/e physicians has worsened over time.[1]

Race, ethnicity, gender, and socioeconomic status can influence characteristics of patient-physician interaction and practice patterns. Physicians of Black, Native American, and Latina/o/e origin are more likely to practice in areas federally designated as medically underserved.[2] For Spanish-speaking Latina/o/e patients, additional implications for health care quality and access can result when the number of Spanish-capable Latina/o/e physicians is insufficient.[3]

Studies of the representation patterns of Latina/o/e medical students, residents, and physicians have thus far focused on these groups as a whole. Studies also suggest that although women physicians bring value to medicine, women of color are especially underrepresented in medicine.[4] Given the potential consequences of this deficiency for health care equity, we analyzed Latina physician demographics in California and the United States, a population that had not specifically been studied before.

Our analysis found that:

1. **Latinas are severely underrepresented in the US physician population.**
    - **Even though the Latina/o/e population comprised almost 18 percent of the US population during the study period, only 6 percent of physicians in the United States were Latina/o/e, and Latinas made up only 2 percent of the US physician population. Non-Hispanic white (NHW) physicians made up 66 percent.**
2. **Latinas are severely underrepresented in the California physician population.**
    - **In California, Latinos comprised 39 percent of the state's population, yet just 6 percent of physicians were Latina/o/e. Latinas made up less than 3 percent of California's physician population.**
3. **Latina physicians are 35.6 times more likely to speak Spanish than NHW physicians.**

Stakeholders have a great opportunity to invest in the future of health equity by addressing the severe shortage of Latina physicians in California and the United States. Our work complements and reinforces current data indicating that efforts to increase the number of individuals underrepresented in medicine have been insufficient to remedy the shortage of Latina/o/e physicians and trainees. The paucity of Latinas suggests that Latina students are not matriculating and proceeding along the training pathway. As a result, they are not represented in the physician workforce at rates comparable to their share of the general population.

This report summarizes research on Latina physician demographics in California and the United States and sheds light on the Latina physician shortage. We offer several recommendations for how policymakers and academic and research professionals can use this analysis to improve representation of this particularly understudied and underrepresented population.

INTRODUCTION

Boosting diversity within the physician workforce is one route to building health equity for increasingly diverse and multiracial populations. Despite recognition of the importance of a diverse workforce and calls to promote diversification by the National Academy of Sciences since 2003,[5] diversity within the profession remains far from parity with population demographics.

The shortage of Latina/o/e physicians has actually worsened over time.[6] In addition, recent data demonstrate a lack of improvement in representation at the resident physician level.[7] Medical school data suggest similar trends. In California, where Latinos made up more than 40 percent of the population in 2022,[8] only about 12 percent of medical school graduates were Latina/o/e.[9] Collectively, these data suggest that efforts intended to diversify the physician trainee and workforce population have been insufficient to successfully address the shortage of Latina/o/e physicians and trainees.

THE VALUE OF PHYSICIAN WORKFORCE DIVERSITY

Identity factors such as race, ethnicity, gender, and socioeconomic status can influence aspects of patient-physician interaction and practice patterns.[10] Physicians of Black, Native American, and Latina/o origin are more likely to practice in areas that are federally designated as medically underserved or experiencing health professional shortages.[11]

Furthermore, for Latina/o/e patients whose preferred language is Spanish, additional implications for health care quality and access can result when the number of Spanish-capable Latina/o/e physicians is insufficient.[12]

Research indicates that when compared to their male physician counterparts, female physicians have longer visits with patients and more frequently engage in communication that is patient-centered.[13] Female physicians also provide preventive care at a higher rate.[14] Hospitalized patients with Medicare have been shown to have lower mortality rates and lower readmission rates when treated by female physicians, producing the estimate that 32,000 fewer patients would die annually if male hospitalists—physicians who practice hospital medicine—achieved the same results as female hospitalists.[15]

AN UNSOLVED PROBLEM

Although the absolute number of women earning degrees in medicine has increased over the years, women of color are especially underrepresented relative to their presence in the workforce and the US population.[16] Because efforts to increase the proportion of individuals underrepresented in medicine (URiMs), especially URiM women, have not had sufficient success, modified and new strategies will need to be pursued at every stage of the education pathway if ongoing shortages are to be rectified. Adequate progress is overdue.

METHODOLOGY

We used data from the US Census Bureau's American Community Survey (ACS) five-year estimates (2014-18) to minimize year-to-year variation. In the ACS, survey respondents self-identify their race/ethnicity as "Hispanic, Latino, or Spanish origin." We report these individuals as "Latina/o/e," in keeping with inclusive practices. When referring to the overall group in this report, we may still use the term "Latino" (e.g., the Latino population), for consistency with the original Census definition. Individuals who identified as "non-Hispanic white" in the Census are reported here as "white." We analyzed the data using SAS 9.4 for Windows, including variables on self-reported occupation and language use.

FINDINGS

Latinos made up 17.8 percent and white individuals made up 61.1 of the US population in the study period (fig. 1). At the same time, only 6.3 percent of the physician population was Latina/o/e, while 65.8 percent was white. Of the groups studied, Latina physicians were the most underrepresented, making up only 2.4 percent of the physician population in the United States. Further details of this analysis can be found **here**.

Figure 1. Share of Physicians by Gender and Race/Ethnicity, United States, 2014-18

White
Latina/o/e
60%
50
40
30
20
10
61.1%
17.8%
65.8%
6.3%
44.4%
3.9%
21.4%
2.4%
U.S. Population
All Physicians
Male Physicians
Female Physicians

Source: CESLAC Tabulations of 2014-18 American Community Survey.

In California, Latina physicians were similarly underrepresented, making up only 2.7 percent of the physician population (fig. 2).

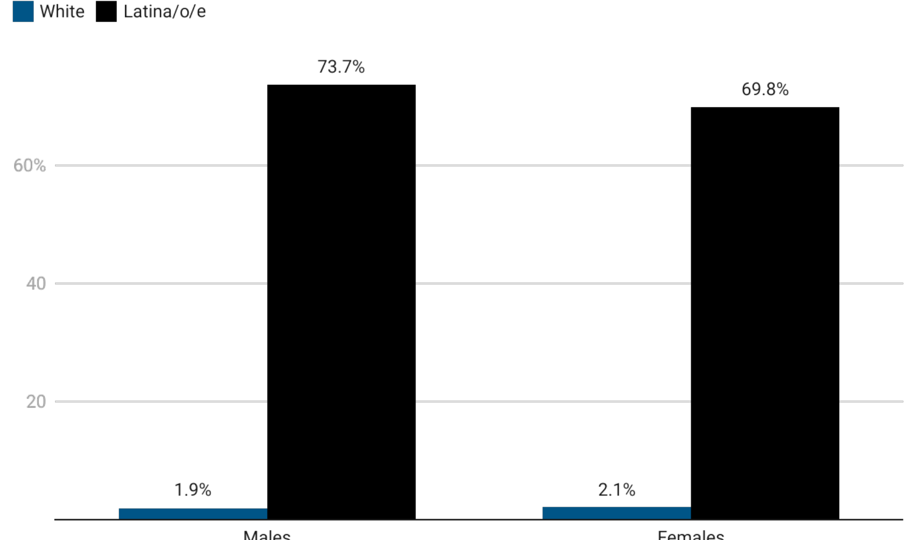
Figure 2. Share of Physicians by Gender and Race/Ethnicity, California, 2014-18

White
Latina/o/e
52.1%
50%
40
37.5%
38.9%
34.4%
30
20
17.7%
10
6.4%
3.7%
2.7%
CA Population
All Physicians
Male Physicians
Female Physicians

Source: CESLAC Tabulations of 2014-18 American Community Survey.

In our analysis of language use, Latina physicians in the United States were 35.6 times more likely to speak Spanish than white physicians as a group. When broken down by gender, 69.8 percent of Latina physicians spoke Spanish at home, whereas only 2.1 percent of white female physicians did so (fig. 3).

Figure 3. Share of Physicians that Speak Spanish at Home by Gender and Race/Ethnicity, United States, 2014-2018



Source: CESLAC Tabulations of 2014-18 American Community Survey.

CONCLUSION

Latina physicians comprised only a tiny portion (2.4 percent) of the total US physician population between 2014 and 2018, despite the Latina/o/e population making up close to one-fifth (17.8 percent) of the US population. In California, where 38.9 percent of the population was Latina/o/e during that time period, all Latina/o/e physicians made up 6.4 percent, and Latinas only 2.7 percent. Latina/o/e enrollment at four-year institutions has continued to rise,[17] but Latina/o/e students are not matriculating into medical school, residency training, or the physician workforce at comparable rates.

Latina physicians are valuable assets to the health care, medical education, and research sectors, yet their numbers are currently insufficient to fill essential roles in these sectors.[18] What more can be done to promote Latina entry into the nation's physician workforce?

It is clear that well-intentioned efforts to promote diversity have not been sufficiently efficacious. We need to adapt past strategies, evaluate new strategies, update best practices, and share these with stakeholders in order to achieve the changes we desire.

As policymakers, the academic and research professions, and the health care industry strategize to improve health care to better meet the needs of patients, it is imperative to focus on expanding the supply of Latina physicians.

To support the acute need for Latina medical students, trainees, and physicians, we recommend a combination of evidence-informed efforts for increasing the number of URiM and STEMM (science, technology, engineering, mathematics, and medicine) students and for supporting the development of efforts targeted at Latinas specifically.[19] These efforts should consider the cumulative effect of the barriers and the discrimination that Latinas may face as women and as individuals with minoritized status, which may include other minoritized statuses beyond Latin American background. To promote sustained improvement in the long term, we recommend that efforts be enacted at each stage of the education pathway to medicine.

RECOMMENDATIONS

K–12 Education

1. Improve outcomes by incorporating evidence-informed education strategies in the classroom from Kindergarten on, including:
   a. Active learning exercises.
   b. Peer-led team learning.

   Research demonstrates that such interventions can be implemented at early stages of the education pathway to increase interest and engagement.[20]

2. Increase educators' effectiveness through lifelong professional learning and continuing education. Federal and state investment is needed to develop ongoing programs that build skills and encourage the evolution of expertise in education strategies, including those that have been shown to promote engagement in STEMM, such as growth mindset, active learning exercises, and peer-led team learning.
   a. Studies suggest that training teachers to have a growth mindset improves students' performance and can be used to recruit female students from STEMM classes into STEMM majors and careers.[21]

Premedical Education

1. Effective advising is essential in undergraduate pre-health programs. State and institutional investment is needed to increase advising support for students interested in pursuing a career in medicine.
   a. Investigate the characteristics and practices of effective pre-health advising support and develop best practices.
   b. Disseminate best practices at community colleges and institutions (including Hispanic-serving institutions) that consistently educate high numbers of URiM students and students with socioeconomic disadvantage.
   c. To promote URiM student success, recruit and invest in developing pre-health advisors who are proactive in their advocacy for students and can employ principles of holistic candidacy, thereby operating under the framework of holistic review, whereby medical schools consider a variety of factors when applications are evaluated. More than a few URiM medical students and physicians have at one time or another had demoralizing experiences with pre-health advising. Pre-health advisors should be trained in allyship, addressing bias, and being antiracist educators.
2. State investment is needed to support community college students, who are likely to be affected by socioeconomic disadvantage, to be URiM, and to practice in underserved communities.[22]
   a. Increase scholarships for qualified community college transfer students who intend to pursue a career in medicine and practice in underserved communities.
   b. Expand programs that provide clinical exposure opportunities for URiM and community college transfer students at no cost.
   c. Expand research opportunities and funding for community college students, both to build medical school application strength and because research experiences encourage URiM students to enter, persist, and advance in STEMM majors.[23]
   d. Fund academic resources and comprehensive support services to ensure success for nontraditional students and student parents with dependents.

Undergraduate and Graduate Medical Education (UME and GME)

1. Adopt evidence-informed admission practices that promote inclusive admissions (see resource **here**).
   a. Use socioeconomic disadvantage scores in the admissions process, alongside MCAT scores and GPAs.[24]
   b. Predetermine selection criteria and their relative weights, thereby creating scoring rubrics for screening, interviews, and rankings.[25] Evaluate the metrics used to judge applicants in UME and GME admissions to make sure they are not biased.
   c. Define measurable outcome equity and inclusion goals before launching recruitment season.[26]
2. Support URiM students already in the education pathway. Protect the ability of DACA and undocumented students and residents to pursue, study, and practice medicine in the United States, and promote routes for their long-term integration as legal permanent residents and citizens.[27]
3. Lean on Centers of Excellence (COEs), funded by the Health Resources and Services Administration (HRSA) to:
   a. Demonstrate sustained objective growth in URiM students and faculty as outcomes.
   b. Demonstrate long-term institutional investment beyond the grant period.
   c. Disseminate to academic institutions across the United States those methods and practices that have produced sustained growth.

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Yohualli B. Anaya M.D., M.P.H. spent 9 years at UCLA (2013-2022) before transitioning to the UW-Madison Department of Family Medicine and Community Health faculty. Dr. Anaya is faculty scholar with the Center for the Study of Latino Health and Culture (CESLAC) and is a faculty expert for LPPI. She is also the Co-Director of the CESLAC Accelerating Latinx Leadership Institute and an Associate Editor for the Family Medicine journal. Her research and scholarly interests include investigating and addressing aspects of health care delivery that act as barriers to health and health care equity, issues of physician workforce diversity, and a focus on the application of research to promote policies and programs that address health equity. As a subject matter expert in telehealth care equity, the Latina physician workforce, and pipeline programs at various levels of the educational and professional pipeline, she has collaborated, and continues to collaborate with LPPI on various research and policy efforts.

As UW-Madison School of Medicine and Public Health faculty, Dr. Anaya teaches residents and medical students full-spectrum inpatient and outpatient Family Medicine and is a primary care doctor at an FQHC. Dr. Anaya previously served as Co-Chair for the Family Medicine Core Clerkship at the David Geffen School of Medicine at UCLA. She has expertise and interest in educating pre-clinical and clinical learners in the care of minoritized populations. Her interests in diversity and inclusion, and social justice in medicine led her to develop a multidimensional pipeline program for high school students.

Dr. Anaya is a graduate of Occidental College, where she obtained a Bachelor of Arts in Biology. She received her medical degree and Master of Public Health from the USC Keck School of Medicine. She completed her residency training at the UCLA Family Medicine Residency Program. Dr. Anaya is passionate about improving the health and healthcare of minoritized and marginalized communities.

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For the past five years, he has been chosen one of the 101 Top Leaders of the Latino Community in the U.S. by Latino Leaders Magazine. In 2012, he received the Association of American Medical Colleges (AAMC) Herbert W. Nickens Award for his lifelong work on the educational, societal, and health care needs of underrepresented groups; and also the Ohtli Award from the Mexican Government in 2016. He graduated from UC Berkeley and completed his M.A. and Ph.D. in medical sociology at the University of California Medical Center, San Francisco.

Seira Santizo Greenwood, B.A. currently serves as the Chief of Staff at UCLA's Center for the Study of Latino Health and Culture (CESLAC) at the David Geffen School of Medicine. She also serves as Director of the UCLA Medical Preparation and Education Pipeline program (MEDPEP). Originally from Guatemala, her path to UCLA was that of a non-traditional, undocumented, transfer student from Santa Monica College whose lived experiences have shaped her research and leadership style. During her 12-year career at UCLA, she has advocated for, empowered, and inspired students and healthcare providers to continue to develop their research and
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Additionally, she serves as a convener for the University of California Office of the President, supporting alumni engagement efforts focused on diversity, inclusion, and equity. Her strategic vision rooted in elevating the U.S. Latino historic narrative inspired her to involve the international dance troupe, Ballet Folklórico Flor de Mayo to help tell the academic story of the real origins and significance of Cinco de Mayo in a publicly accessible way. Her research interests focus on the health outcomes of racially ambiguous populations and on the uses of the Latino Double Impostor Syndrome in health care leadership and equity.