COVID-19 and Latinx Disparities: Highlighting the Need for Medical Schools to Consider Accepting DACA Recipients

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Abstract

COVID-19 revealed and magnified the preexisting health inequities faced by many vulnerable groups. The Latinx community is one of these groups and has borne the brunt of disparate rates of infection, hospitalization, and mortality associated with COVID-19. These disparities are rooted in social inequities, such as poverty and lack of access to health care, as well as health inequities associated with disparate disease and condition burdens. Moreover, the lack of an adequate Latinx physician workforce contributes to and exacerbates these inequities. The COVID-19 pandemic has intersected with the U.S. Supreme Court’s decision in the Department of Homeland Security v. Regents of the University of California case. The court’s decision in this case struck down the attempted ending of the Deferred Action for Childhood Arrivals (DACA) program, although it was settled that the government could end the program if it was done lawfully. Even though this constitutes a win for DACA recipients, the decision is a stopgap as the future of DACA recipients remains vulnerable and subject to other legal challenges and political vagaries. In a time when the need to ameliorate health inequities for the Latinx community is so pronounced, DACA recipient medical trainees could provide much-needed relief. Since the implementation of DACA, some medical schools have decided to accept DACA recipient students, but many do not. This access-limiting practice stymies a group of potential trainees who could help to increase the Latinx physician workforce, as the majority of DACA recipients are Latinx. This article argues that all medical schools should take steps to consider accepting DACA recipient applicants in line with the principles of health equity and suggests 5 recommendations for medical school admissions, support, and advocacy practices.

This article seeks to add to the arguments made by others, within the context of COVID-19 and with a focus on the Latinx population, that Deferred Action for Childhood Arrivals (DACA) recipients should be afforded the opportunity to fully participate in medical training. My hope in writing this article is that medical schools will respond by considering the acceptance of DACA recipient students, guided by the principles of health equity, for the public good.

On June 18, 2020, the U.S. Supreme Court issued its ruling in the Department of Homeland Security v. Regents of the University of California case, also known as the DACA case. The court’s 5-4 decision held that the manner in which the government attempted to end DACA was “arbitrary and capricious,” in violation of the Administrative Procedure Act, and therefore illegal. The court reasoned that the government failed its legal responsibility to consider the reliance interests of DACA recipients. That is, the government was obligated to consider whether the granting of DACA status to individuals led those individuals to reasonably rely on this status when choosing to enroll in education programs, enlist in military service, purchase homes, etc., and whether these interests were significant interests when deciding to end DACA. Although a win for DACA recipients, this decision is yet another stopgap, as the future of DACA recipients remains vulnerable to other legal challenges and subject to political vagaries.

The DACA case decision comes at a time when the country and world are grappling with the devastating impacts of COVID-19. The emergence of COVID-19 highlighted the inadequacy of the nation’s health care infrastructure, medical supply stockpiles, and health care workforce to meet the challenge of a pandemic. During a time when the nation is in need of health care professionals to manage COVID-19 hotspots and surges and to assist with vaccine administration and education, DACA recipient physicians and other DACA recipient medical personnel are needed more than ever. Compounding these general public health needs are the disparate health and mortality impacts from COVID-19 on the Latinx population and other minoritized groups in the United States. The intersection of DACA policy—a legal mechanism that can be used to supply much-needed Latinx physicians—and the COVID-19 pandemic is a watershed moment for the country.

DACA Background

The creation of the DACA program was precipitated by a long history of failed immigration policy reform. In 2001, the Development, Relief, and Education for Alien Minors (DREAM) Act was introduced to Congress to allow a pathway for undocumented students to obtain authorized legal status in the form of permanent residency. These individuals who were brought to the United States as children, knew no other country as home, and had engaged in educational or employment pursuits in the United States became known as Dreamers. The DREAM Act was ultimately unsuccessful, but subsequent bills were introduced to...
Congress with variations of the language from the DREAM Act, with the aim of providing some pathway to authorized residency status for individuals brought to the United States as minors. These bills, which were introduced under 2 presidential administrations over the course of 11 years, were unsuccessful in garnering the necessary congressional votes to become law.

In 2012, still with no such law passed, President Barack Obama sought a temporary measure to address the status of Dreamers. On June 15, 2012, in a Rose Garden address, President Obama said, “in the absence of any immigration action from Congress to fix our broken immigration system, what we’ve tried to do is focus our immigration enforcement resources in the right places.” On that same day, Secretary of Homeland Security, Janet Napolitano, issued a memorandum directing U.S. immigration agencies to use “prosecutorial discretion” when deciding whether to enforce immigration removal proceedings for individuals who came to the United States as children. Upon meeting certain criteria—age requirements, continuous presence in the country, education requirements or military service, and absence of certain legal convictions—an individual may be deemed low-priority for removal and immigration agencies should not use resources to remove these low-priority individuals from the country (i.e., they should be granted a temporary deferral of deportation). This prosecutorial discretion underpins the DACA policy, and those who meet the qualifications given above may participate in DACA, renewable after 2 years, by submitting an application and paying a filing fee.

From its inception, DACA was a controversial government program with opponents viewing the program as an executive branch overreach that circumvented congressional authority to set immigration policy. In 2016, a pursuit to end DACA was part of some highly charged campaign promises—including building a wall at the United States-Mexico border—made by then-presidential candidate Donald Trump, who claimed that DACA was illegal. After his election, the Trump administration issued a memorandum in 2017 that it would be ending DACA, which was swiftly met by legal challenges that culminated in the U.S. Supreme Court DACA case ruling in June 2020 (see above). Since the creation of DACA, more than 825,000 individuals have been granted deportation relief. The vast majority of DACA recipients are Latinx. In 2020, 93.5% (772,516) of the 825,998 DACA recipients hailed from Latin American countries. Mexicans constituted the largest Latinx group at 78.7% (650,353) of all DACA recipients. Comparatively, South Korea was the top non-Latin American country with 1.1% (9,011) of DACA recipients. The top 5 states in terms of residences for DACA recipients in order from most to least include recipients were California, Texas, Illinois, New York, and Florida. Collectively, these 5 states accounted for 59.4% (490,945) of all DACA recipients’ residences.

**Importance of the Latinx Physician Workforce**

Latinx representation among physicians and medical school students is deficient. In 2018, only 5.8% of active physicians were Latinx, and similarly, only 6.2% of medical school matriculants in 2018–2019 were Latinx. The numbers of active Latinx physicians and medical school matriculants fall short of proportionally representing the general U.S. Latinx population, which stands at 18.7% as of 2020. This 3-fold representational disproportionality is critical because a diverse physician workforce increases patient access to care, improves culturally competent care of patients, and positively impacts diverse patients’ satisfaction with their care. Latinx physicians may be more likely to speak Spanish than non-Latinx physicians, and physician-language concordance has been connected to positive health outcomes for Latinx patients. Latinx physicians have also been shown to be more likely to care for Latinx patients and serve in underserved communities. Moreover, research has suggested that diversifying the physician workforce will lead to improvements in health care disparities for underserved populations.

The Latinx community suffers from a variety of health disparities. For example, Latinx children are 40% more likely to die from asthma than White children, Latinx individuals are twice as likely as Whites to develop and die from liver cancer, and Latinx men with human immunodeficiency virus (HIV) die at twice the rate of White men with HIV. These disparities may be mitigated by having more Latinx physicians to care for the Latinx population, as suggested by the Institute of Medicine’s pioneering work, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” which recommended diversifying the physician workforce to help mitigate health care disparities for minoritized groups. This should, however, not be interpreted to mean that only Latinx physicians should and can provide quality care to the Latinx community or that Latinx physicians cannot provide quality care to other groups. Nonetheless, more Latinx physicians and Latinx physician trainees are needed to help meet the care needs of the Latinx population.

The Association of American Medical Colleges (AAMC) reported in 2019 that there are nearly 200 DACA recipient medical students and residents training in the United States. Although the AAMC does not release race/ethnicity data for non–U.S. citizens or nonpermanent residents, given the large percentage of DACA recipients who are Latinx, it is reasonable to presume a substantial percentage of these current DACA recipient medical trainees are Latinx. Indicatively, a 2020 report from the Presidents’ Alliance on Higher Education and Immigration estimated nearly 188,000 DACA recipient and DACA eligible students are currently attending undergraduate institutions; an estimated 65% (122,000) of these students are Latinx. This represents a significant and immediate pipeline of Latinx DACA recipient and DACA eligible students preparing to potentially apply to medical school.

The academic medical community has limited medical education access to DACA recipients. In 2018, the AAMC reported a partial list of only 73 of the more than 150 MD-granting medical schools that accepted DACA recipient students. Further, among those that do accept DACA recipient students, some schools treat these students differently by giving preference to in-state DACA recipient students versus out-of-state DACA recipient students or giving preference to U.S. citizens or permanent residents. Other schools accept DACA recipient students but only if they can demonstrate the ability to pay for their education.
medical education because DACA recipient students do not qualify for federal financial aid. Admission to medical school is highly competitive and this competitiveness is inequitably exacerbated by removing a large number of application opportunities for DACA recipient students, as well as by treating DACA recipient students differently during the admissions process. Admission to medical school is multifactorial and complex; however, it has been estimated that the country has the potential to gain 5,400 DACA recipient physicians in the coming decades, which will be more readily achieved by equitable medical school admissions practices.

Facilitating the entry of DACA recipient physicians into the workforce—many of whom will likely be Latinx—serves the just aim of treating persons fairly regardless of their citizenship status and could help to address the dire need to mitigate health inequities that were already present before but that have been starkly revealed and magnified by COVID-19.

**COVID-19’s Inequitable Impacts on the Latinx Community**

The Centers for Disease Control and Prevention (CDC) describes health equity as being “achieved when every person has the opportunity to ‘attain his or her full health potential’ and no one is ‘disadvantaged from achieving this potential because of social position or other socially determined circumstances.’” Although a nondiscriminatory disease in its ability to infect all, COVID-19 was discriminatory in that it exploited and laid bare the social and health disadvantages of many from the Latinx community.

As of December 13, 2021, there have been 50,052,008 COVID-19 cases reported in the United States and more than 796,010 individuals have died from the virus. Where race/ethnicity is known, the CDC reports that 24.7% (6,800,961) of cases and 17.3% (136,134) of deaths have been Latinx individuals. The Latinx share of COVID-19 cases is outsized compared with the Latinx share of the national population (18.7%). Although Latinx COVID-19 deaths represent a slightly smaller total percentage when compared with the Latinx share of the national population, when age-adjusted to consider the different age distributions across racial/ethnic groups, the CDC reports that Latinx individuals are actually 2.1 times more likely to die from COVID-19 than Whites. Additionally, some states with large Latinx populations have seen significant overrepresentation of both Latinx COVID-19 deaths and cases. For example, in California—the state with the largest Latinx population—Latinx individuals represent 38.9% of the population but have accounted for 52.4% (2,074,108) of all cases and 45.5% (33,283) of all deaths related to COVID-19. In Texas—the state with the second-largest Latinx population—Latinx individuals represent 39.7% of the population but account for 40.2% (28,800) of COVID-19 cases and 46.4% (23,900) of COVID-19–related deaths. Moreover, ratios of age-adjusted rates reported by the CDC reveal that Latinx individuals are 1.6 times more likely to contract COVID-19 and 2.5 times more likely to be hospitalized for COVID-19 than Whites.

Research indicates that these alarming Latinx COVID-19 health disparities are tied to social inequities, such as poverty, type of employment, living conditions, and lack of access to health care. In 2019, the Latinx community had the second-highest poverty rate among racial/ethnic groups in the United States at 15.7%, compared with only 7.3% for Whites (who were tied for the lowest poverty rate with Asians). Likewise, many Latinx individuals work in jobs that have been deemed essential, which do not tend to have flexibility in terms of the ability to work from home (e.g., farming, transportation, service jobs). This work inflexibility increases these individuals’ chances of being exposed to COVID-19. Crowded living conditions, which make it difficult to practice social distancing, is another factor for transmission, and Latinx individuals are more likely than Whites to live in multigenerational homes. The Latinx community is the racial/ethnic group with the largest proportion of uninsured individuals in the United States, with 17.8% uninsured, compared with only 5.9% of Whites. This lack of insurance makes access to health care a challenge. Compounding social risk factors, Latinx individuals also suffer from disparate disease and condition burdens that have been associated with more severe cases of COVID-19. For example, Latinx individuals are 1.7 times more likely to be diagnosed with diabetes and 1.2 times more likely to be obese than Whites. These preexisting social inequities and health disparities have compounded the devastation of the COVID-19 pandemic for the Latinx community.

Efforts to address the underlying health inequities that the Latinx community was already facing before the pandemic, including increasing the Latinx physician workforce, will be paramount in alleviating the disparate impacts of COVID-19. Moreover, as the COVID-19 vaccines are administered, addressing vaccine hesitancy among the Latinx community will be critical. Building trust between the Latinx community and the medical community will be exceedingly important given the history of forced sterilization and other abuses that the Latinx population and other minoritized groups have experienced at the hand of the medical community. Latinx physicians and physicians in training who can communicate in Spanish and culturally appropriate ways can help to reassure the Latinx community to get vaccinated. Still, even after COVID-19 is controlled, a need to have an adequate Latinx physician workforce will remain to help mitigate the remaining health disparities experienced by the Latinx community.

**Recommendations for Medical Schools**

The U.S. Supreme Court decision to disallow the federal government to end the DACA program was a temporary victory for DACA recipients. It is well settled that the executive branch of government has the legal authority to end the program but only with due consideration of DACA recipients’ reliance interests. Thus, the court’s DACA case decision represents the end of a legal chapter, but the saga will continue for DACA recipients, including medical trainees and medical trainee hopefuls, who await any future efforts to end DACA and further political actions that could affect their status. Most recently, on July 16, 2021, the U.S. District Court for the Southern District of Texas held that DACA was unlawful as it violated the Administrative Procedure Act and that no new DACA applications could be approved by the U.S. Department of
Homeland Security, but did not go so far as to terminate DACA statuses for existing DACA recipients. Fortunately, President Joe Biden signed an executive order to “preserve and fortify” DACA and introduced a bill to Congress that would allow for DACA recipients to immediately be eligible for Green Cards and apply for citizenship after 3 years once the bill becomes law.overshadow DACA recipients and DACA eligible individuals will continue to await the fate of this bill or other similar bills addressing DACA and of a legal appeal of the most recent ruling on DACA. Despite the vulnerability of DACA, medical schools should consider accepting DACA recipient applicants, in part, to help address the Latinx physician workforce needs magnified by COVID-19 but also to advance equitable medical school admissions processes. To this end, I suggest 5 recommendations for medical school admissions, support, and advocacy practices below.

Recommendation 1: All medical schools should consider applications from DACA recipients

The government established a deportation deferral program for DACA recipients, in part, to facilitate the continued contributions of these individuals, including educational and employment pursuits for the betterment of the public good. All medical schools should honor this aim not only out of a sense of equity and social justice but because the health of marginalized groups, including the Latinx community, will stand to benefit from a workforce with more Latinx physicians. The law recognizes equal treatment for individuals despite their citizenship status (i.e., refugees, asylees, permanent residents) via the Immigration and Nationality Act. Underlying this law is the tenet of protection from unjust discrimination. Although having DACA status does not rise to the level of the groups protected by the Immigration and Nationality Act, because DACA recipients are considered undocumented, medical schools should treat DACA recipients equally, in line with the values of an equitable admissions process.

Recommendation 2: All medical schools should eliminate the practice of prioritizing or only accepting in-state DACA recipient applicants

For those medical schools that already accept or are considering accepting DACA recipient students, they should not limit DACA recipient student acceptance to only those applicants who are in-state or give priority to in-state versus out-of-state applicants. These access-limiting admissions practices create additional hurdles for DACA recipient applicants, who may live in a state with medical schools that do not accept DACA recipient applicants. These applicants will have to apply to out-of-state schools and then may be at a disadvantage applying to a school that prioritizes in-state DACA recipient applicants. Although medical schools may have various interests in prioritizing in-state applicants versus out-of-state applicants, such as yield rates or building a “home grown” workforce, the national medical school landscape is currently too skewed to the disadvantage of DACA recipient students to engage in such limiting admissions practices.

Recommendation 3: All medical schools should create a plan to develop scholarship opportunities for DACA recipient students

Because DACA recipient students do not currently qualify for federal financial aid, medical schools should create development plans to raise funds to offset the costs of attending medical school for DACA recipient students specifically. The average cost of medical school tuition at a private school is $57,336 per year. The average cost of medical school tuition at a public school, however, varies widely as in-state students pay $33,489 per year and out-of-state students pay $56,351 per year. Some states have barred all DACA recipient students from paying tuition in-state tuition—reasons for this range from the belief that allowing in-state tuition encourages illegal immigration to arguments that this violates certain state laws—leaving them to pay much more for their medical education. Financing the high cost of medical school is very likely a deterrent for many qualified DACA recipient students.

Recommendation 4: All medical schools should ensure wellness and support services are in place for DACA recipient students

Having adequate student support and wellness services is key to student success in medical school. DACA recipient students may face additional hurdles compared with other students. As noted by Balderas-Medina Anaya and colleagues, DACA recipient students may report feelings of sadness and fear given uncertainty related to their undocumented status. Appropriate training of not only student affairs staff but also all faculty and staff related to DACA recipient students should be required.

Recommendation 5: All medical schools should advocate for guaranteed opportunities for DACA recipient physicians to obtain medical licensure

Upon medical school graduation, DACA recipients generally have the ability to apply to and match in medical residency programs provided that they obtain employment authorization, pass the United States Medical Licensing Examination Step 1 and Step 2, and satisfy a criminal background check. The extension of a clear path to obtain medical licensure and perhaps work in the community where a DACA recipient resident trained may alleviate the hesitancy of medical residency programs that are considering accepting DACA recipients. Professional licensing eligibility is governed by individual states, and only some states have expanded professional licensing eligibility to include DACA recipients. California and Nevada, for example, have made it illegal to deny professional licensure based on citizenship or immigration status, which includes DACA status. Medical schools should advocate to state legislators and governing bodies to explicitly cover DACA recipients as eligible for medical licensure, as well as to federal legislators to enact legislation to repeal state and federal prohibitions on professional licensure eligibility based on citizenship or immigration status.

Conclusions

The confluence of COVID-19 and DACA policy and their collective impacts on the Latinx community have highlighted a need for action. The pandemic heightened the vulnerability of Latinx individuals due to social inequities and other health disparities. An urgent need for more Latinx physicians to help mitigate COVID-19 impacts and the preexisting underlying health inequities for the Latinx community is clear. Fortunately, nearly 10 years after its inception, DACA survives and still offers a legal mechanism to increase the
Latinx physician workforce. The time has come for medical schools to engage in equitable admissions, support, and advocacy practices and to commit to the successful completion of training of DACA recipient students for the benefit of not only the Latinx community but also of U.S. society as a whole.

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