The Undue Burden the Medical School Application Process Places on Low-Income Latinos

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ABSTRACT

The demographic of physicians in the United States has failed to include a proportionate population of Latinos in the United States. In what follows, I shall argue that the medical school admission process places an undue burden on low-income Latino applicants. Hence, the underrepresentation of Latinos in medical schools is an injustice. This injustice relates to the poor community health of the Latino community. Health disparities such as diabetes, HIV infection, and cancer mortality are higher amongst the Latino community. The current representation of Latino medical students is not representative of those in the United States.

Keywords: Medical School, Latinos, Marginalized Community, Health Disparity, Physician Demographic

INTRODUCTION

The demographic of physicians in the United States has failed to include a proportionate number of Latinos, meaning people of Latin American origin. Medical schools serve as the gatekeepers to the medical field, and they can alter the profession based on whom they admit. With over 60 million Latinos in the United States, people of Latin American origin comprise the largest minority group in the nation.[1] In 2020-2021, only 6.7 percent of total US medical school enrollees and only 4 percent of medical school leadership identified as Latino.[2] Latino physicians can connect to a historically marginalized community that faces barriers including language, customs, income, socioeconomic status, and health literacy. I argue that the medical school admissions process places an undue burden on low-income Latino applicants. This paper explores the underrepresentation of Latinos in medical schools as an injustice. A further injustice occurs as the barriers to medical education result in fewer Latino doctors to effectively deliver health care and preventive health advice to their communities in a culturally competent way.

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I. Latino Community Health Data

The terms Latino and Hispanic have largely been considered interchangeable. US government departments, such as the US Census Bureau and the Centers for Disease Control and Prevention (CDC), define Hispanic people as those with originating familial ties to native Spanish-speaking countries, most of whom are from Latin America. The term Latino is more inclusive because it refers to all of those with strong originating ties to countries in Latin America, including those coming from countries such as Brazil and Belize who are not native Spanish speakers. Throughout this work, I refer to the term Latino because it is more inclusive, although the data retrieved from US government departments may refer to the population as Hispanic. "Low-income" refers to the qualifying economic criteria for the AAMC's Fee Assistance Program Poverty Guidelines.[3] The AAMC Fee Assistance Program is designed to help individuals who do not have the financial means to pay the total costs of applying to medical school. For this paper, low-income refers to those who qualify for this program.

The US government gathers data about Latino community health and its health risks. The Latino community has a higher poverty rate than the non-Hispanic white community.[4] Latino community health has long trailed that of white people collectively. For example, the Latino community experiences higher levels of preventable diseases, including hypertension, diabetes, and hepatitis, than the non-Hispanic white community does.[5]

The CDC collects data about Latino community health and provides statistics to the public. Latinos in the United States trail only non-Hispanic blacks in prevalence of obesity. The Latino adult obesity rates are 45.7 percent for males and 43.7 percent for females.[6] Of the 1.2 million people infected with HIV in the United States, 294,200 are Latino.[7] The infection rate of chlamydia is 392.6 per 100,000 — 1.9 times the rate in the non-Hispanic white population.[8] The tuberculosis incidence rate is eight times higher than that of non-Hispanic white people at 4.4 per 100,000.[9] Furthermore, Latinos have the third highest death rate for hepatitis C among all races and ethnic groups.[10] The prevalence of total diabetes, diagnosed and undiagnosed, among adults aged 18 and older also remains higher than that of non-Hispanic whites at 14.7 percent compared to 11.9 percent.[11]

The high disease rate evidences the poor health of the community. Furthermore, 19 percent of Latinos in the United States remain uninsured.[12] Almost a quarter of the Latino population in the United States lives in poverty.[13] The high incidence of disease, lack of insurance, and high poverty rate create a frail health status for the Latino community in the United States. The medical conditions seen are largely preventable, and the incident rates can be lowered with greater investments in Latino community health. Considering the health disparities between Latino and non-Hispanic White people, there is an ethical imperative to provide better medical care and guidance to the Latino community.

II. Ethical and Practical Importance of Increasing the Number of Latino Physicians

Minorities respond more positively to patient-physician interactions and are more willing to undergo preventative healthcare when matched with a physician of their racial or ethnic background.[14] Latino medical doctors may lead to an improvement in overall community health through improved communication and trusting relationships. Patient-physician racial concordance leads to greater patient satisfaction with their physicians.[15] Identifying with the ethnicity of a physician may lead to greater confidence in the physician-patient relationship, resulting in more engagement on the patient's behalf. A randomized study regarding African American men and the race of their attending physician found an

increase in requests for preventative care when assigned to a black doctor.[16] Although the subjects were African American men, the study has implications applicable to other minority racial and ethnic groups.

The application process is unjust for low-income Latinos. The low matriculation of Latinos in medical schools represents a missed opportunity to alleviate the poor community health of the Latino population in the United States. Medical school also would create an opportunity to address health issues that plague the Latino community. Becoming a physician allows low-income Latinos to climb the social ladder and enter the spaces in health care that have traditionally been closed off to them.

Nonwhite physicians significantly serve underserved communities.[17] Increasing the number of Latino doctors can boost their presence, potentially improving care for underserved individuals. Teaching physicians cultural competence is not enough to address the health disparities the Latino community faces. Latino physicians are best equipped to understand the healthcare needs of low-income Latinos. I contend that reforming the application process represents the most straightforward method to augment the number of Latino physicians who wish to work in predominantly Latino or diverse communities, thereby improving healthcare for the Latino community.

III. Cultural Tenets Affecting Healthcare Interactions

"Poor cultural competence can lead to decreased patient satisfaction, which may cause the patient not to attend future appointments or seek further care."[18] Latino community health is negatively affected when medical professionals misinterpret cultural beliefs. Cultural tenets like a reservation towards medication, a deep sense of respect for the physician, and an obligation to support the family financially and through advocacy affect how Latinos seek and use the healthcare system.[19]

First, the Latino population's negative cultural beliefs about medication add a barrier to patient compliance. It is highlighted that fear of dependence upon medicine leads to trouble with medication regimens.[20] The fear stems from the negative perception of addiction in the Latino community. Taking as little medication as possible avoids the chance of addiction occurring, which is why many take the prescribed medicine only until they feel healthier, regardless of the prescribing regimen. Some would rather not take any medication because of the deep-rooted fear. Physicians must address this concern by communicating the importance of patient compliance to remedy the health issue. Explaining that proper use of the medication as prescribed will ensure the best route to alleviate the condition and minimize the occurrence of dependence. Extra time spent addressing concerns and checking for comprehension may combat the negative perception of medication.

Second, the theme of respeto, or respect, seems completely harmless to most people. After all, how can being respectful lead to bad health? This occurs when respect is understood as paternalism. Some patients may relinquish their decision-making to the physician. The physician might not act with beneficence, in this instance, because of the cultural dissonance in the physician-patient relationship that may lead to medical misinterpretation. A well-meaning physician might not realize that the patient is unlikely to speak up about their goals of care and will follow the physician's recommendations without challenging them. That proves costly because a key aspect of the medical usefulness of a patient's family history is obtaining it through dialogue. The Latino patient may refrain from relaying health concerns because of the misconceived belief that it's the doctor's job to know what to ask. Asking the physician questions may be considered a sign of disrespect, even if it applies to signs, symptoms, feelings, or medical procedures the patient may not understand.[21] Respeto is dangerous because it restricts the patients from playing an active role in their health. Physicians cannot derive what medical information may be relevant to the patient without their

cooperation. And physicians without adequate cultural competency may not know they need to ask more specific questions. Cultural competency may help, but a like-minded physician raised similarly would be a more natural fit.

"A key component of physician-patient communication is the ability of patients to articulate concerns, reservations, and lack of understanding through questions."[22] As a patient, engaging with a physician of one's cultural background fortifies a strong physician-patient relationship. Latino physicians are in the position to explain to the patients that respeto is not lost during a physician-patient dialogue. In turn, the physician can express that out of their value of respeto, and the profession compels them to place the patient's best interest above all. This entails physicians advocating on behalf of the patients to ask questions and check for comprehension, as is required to obtain informed consent. Latino physicians may not have a cultural barrier and may already organically understand this aspect of their patient's traditional relationship with physicians. The common ground of respeto can be used to improve the health of the Latino community just as it can serve as a barrier for someone from a different background.

Third, in some Latino cultures, there is an expectation to contribute to the family financially or in other ways and, above all, advocate on the family's behalf. Familial obligations entail more than simply translating or accompanying family members to their appointments. They include actively advocating for just treatment in terms of services. Navigating institutions, such as hospitals, in a foreign landscape proves difficult for underrepresented minorities like Latinos who are new to the United States. These difficulties can sometimes lead to them being taken advantage of, as they might not fully understand their rights, the available resources, or the standard procedures within these institutions. The language barrier and unfamiliar institutional policies may misinterpret patients' needs or requests. Furthermore, acting outside of said institution's policy norms may be erroneously interpreted as actions of an uncooperative patient leading to negative interactions between the medical staff and the Latino patient.

The expectation of familial contribution is later revisited as it serves as a constraint to the low-income Latino medical school applicant. Time is factored out to meet these expectations, and a moral dilemma to financially contribute to the family dynamic rather than delay the contribution to pursue medical school discourages Latinos from applying.

IV. How the Medical School Admission Process is Creating an Undue Burden for Low-Income Latino Applicants

Applying a bioethics framework to the application process highlights its flaws. Justice is a central bioethical tenet relevant to the analysis of the MD admissions process. The year-long medical school application process begins with the primary application. The student enters information about the courses taken, completes short answer questions and essays, and uploads information about recommenders. Secondary applications are awarded to some medical students depending on the institutions' policies. Some schools ask all applicants for secondary applications, while others select which applicants to send secondary requests. Finally, interviews are conducted after a review of both primary and secondary applications. This is the last step before receiving an admissions decision.

The medical school application process creates undue restrictions against underserved communities. It is understood that matriculating into medical school and becoming a doctor should be difficult. The responsibilities of a physician are immense, and the consequences of actions or inactions may put the patients' lives in jeopardy. Medical schools should hold high standards because of the responsibility and expertise required to provide optimal healthcare. However, I argue that the application process places an

undue burden on low-income Latino applicants that is not beneficial to optimal health care. The burden placed on low-income Latino applicants through the application process is excessive and not necessary to forge qualified medical students.

The financial aspect of the medical school application has made the profession virtually inaccessible to the working class. The medical school application proves costly because of the various expenses, including primary applications, secondary applications, and interview logistics. There is financial aid for applications, but navigating some aid to undertake test prep, the Medical College Admission Test (MCAT), and the travel for interviews proves more difficult. Although not mandatory, prep courses give people a competitive edge.[23] The MCAT is one of the key elements of an application, and many medical schools will not consider applications that do not reach their score threshold. This practically makes the preparatory courses mandatory for a competitive score. The preparatory courses themselves cost in the thousands of dollars. There has been talk about adjusting the standardized test score requirements for applicants from medically underserved backgrounds. I believe the practice of holding strict cutoffs for MCAT scores is detrimental to low-income Latino applicants, especially considering the average MCAT scores for Latinos trail that of white people. The American Association of Medical Colleges' recent data for the matriculating class of 2021 illustrates the wide gap in MCAT scores: Latino applicants average 500.2, and Latino matriculants average 506.6, compared to white applicants, who average 507.5 and white matriculants, who average 512.7.[24] This discrepancy suggests that considerations beyond scores do play some role in medical school matriculation. However, the MCAT scores remain a predominant factor, and there is room to value other factors more and limit the weight given to scores. The practice of screening out applicants based solely on MCAT scores impedes low-income Latino applicants from matriculating into medical school. Valuing the MCAT above all other admissions criteria limits the opportunities for those from underserved communities, who tend to score lower on the exam. One indicator of a potentially great physician may be overcoming obstacles or engaging in scientific or clinical experiences. There are aspects of the application where the applicant can expand on their experiences, and the personal statement allows them to showcase their passion for medicine. These should hold as much weight as the MCAT. The final indicator of a good candidate should not solely rest on standardized tests.

There is a cost per medical school that is sent to the primary application. The average medical school matriculant applies to about 16 universities, which drives up the cost of sending the applications.[25] According to the American Association of Medical Colleges, the application fee for the first school is $170, and each additional school is an additional $42. Sending secondary applications after the initial application is an additional cost that ranges by university. The American Medical College Application Service (AMCAS), the primary application portal for Medical Doctorate schools in the United States and Canada, offers the Fee Assistance Program (FAP) to aid low-income medical school applicants. The program reduces the cost of the MCAT from $325 to $130, includes a complimentary Medical School Admission Requirements (MSAR) subscription, and fee waivers for one AMCAS application covering up to 20 schools.[26] The program is an important aid for low-income Latino students who would otherwise not be able to afford to send multiple applications. Although the aid is a great resource, there are other expenses of the application process that the program cannot cover.

For a low-income applicant, the burden of the application cost is felt intensely. A study analyzing the American Medical College Application Service (AMCAS) data for applicants and matriculants from 2014 to 2019 revealed an association between income and acceptance into medical school. They state, "Combining all years, the likelihood of acceptance into an MD program increased stepwise by income. The adjusted rate of acceptance was 24.32 percent for applicants with income less than $50 000, 27.57 percent for $50

000 - $74 999, 29.90 percent for $75 000 - $124 999, 33.27 percent for $125 000 - $199 999, and 36.91 percent for $200,000 or greater."[27] It becomes a discouraging factor when it is difficult to obtain the necessary funds.

The interview process for medical schools may prove costly because of travel, lodging, and time. In-person interviews may require applicants to travel from their residence to other cities or states. The applicant must find their own transportation and housing during the interview process, ranging from a single day to multiple days. Being granted multiple interviews becomes bittersweet for low-income applicants because they are morally distraught, knowing the universities are interested yet understanding the high financial cost of the interviews. The expense of multiple interviews can impede an applicant from progressing in the application process. Medical schools do not typically cover travel expenses for the interview process.

Only 4 percent of medical school faculty identify as Latino.[28] The medical school admission board members reviewing the application lack Latino representation.[29] Because of this, it is extremely difficult for a low-income Latino applicant to portray hardships that the board members would understand. Furthermore, the section to discuss any hardships only allows for 200 words. This limited space makes it extremely difficult to explain the nuances of navigating higher education as a low-income Latino. Explaining those difficulties is then restricted to the interview process. However, that comes late in the application process when most applicants have been filtered out of consideration. The lack of diversity among the board members, combined with the minimal space to explain hardships or burdens, impedes a connection to be formed between the Latino applicants and the board members. It is not equitable that this population cannot relate to their admissions reviewers because of cultural barriers.

Gatekeeping clinical experience inadvertently favors higher socioeconomic status applicants. Most medical schools require physician shadowing or clinical work, which can be difficult to obtain with no personal connections to the field. Using clinical experience on the application is another way that Latinos are disadvantaged compared to people who have more professional connections or doctors in the family and social circles. The already competitive market for clinical care opportunities is reduced by nepotism, which does not work in favor of Latino applicants. Yet some programs are designed to help low-income students find opportunities, such as Johns Hopkins' Careers in Science and Medicine Summer Internship Program, which provides clinical experience and health professions mentoring.[30] Without social and professional ties to health care professionals, they are forced to enter a competitive job and volunteer market in clinical care and apply to these tailored programs not offered at all academic institutions.

While it is not unique to Latinos, the time commitment of the application process is especially harsh on low-income students because they have financial burdens that can determine their survival. Some students help their families pay for food, rent, and utilities, making devoting time to the application process more problematic.

As noted earlier, Latino applicants may also have to set aside time to advocate for their families. Because the applicants tend to be more in tune with the dominant American culture, they are often assigned the family advocate role. They must actively advocate for their family members' well-being. The role of a family advocate, with both its financial and other supportive roles ascribed to low-income Latino applicants, is an added strain that complicates the medical school application. As a member of a historically marginalized community, one must be proactive to ensure that ethical treatment is received. Ordinary tasks such as attending a doctor's appointment or meeting with a bank account manager may require diligent oversight. Applicants must ensure the standard of service is applied uniformly to their family as it is to the rest of the population. This applies to business services and healthcare.

It can be discouraging to approach a field that does not have many people from your background. The lack of representation emphasizes the applicant's isolation going through the process. There is not a large group of Latinos in medicine to look to for guidance.[31] The group cohesiveness that many communities experience through a rigorous process is not established among low-income Latino applicants. They may feel like outsiders to the profession. Encountering medical professionals of similar backgrounds gives people the confidence to pursue the medical profession.

V. Medical School Admission Data

This section will rely on the most recent MD medical school students, the 2020-2021 class. The data includes demographic information such as income and ethnicity. The statistics used in this section were retrieved from scholarly peer-reviewed articles and the Medical School Admission Requirement (MSAR) database. Both sources of data are discussed in more detail throughout the section. The data reveals that only 6.7 percent of medical students for the 2020-2021 school year identify as Latino.[32]

The number of Latino students in medical school is not proportional to the Latino community in the United States. While Latinos comprise almost 20 percent of the US population (62.1 million), they comprise only 6.7 percent of the medical student population.[33] Below are three case studies of medical schools in cities with a high Latino population.

VI. Medical School Application Process Case Studies

a) New York University Grossman School of Medicine is situated in Manhattan, where a diverse population of Latinos reside. The population of the borough of Manhattan is approximately 1,629,153, with 26 percent of the population identifying as Latino.[34] As many medical schools do, Grossman School of Medicine advertises an MD Student Diversity Recruitment program. The program, entitled Prospective MD Student Liaison Program, is aimed such that "students from backgrounds that are underrepresented in medicine are welcomed and supported throughout their academic careers."[35] The program intervenes with underrepresented students during the interview process of the medical school application. All students invited to interviews can participate in the Prospective MD Student Liaison Program. They just need to ask to be part of it. That entails being matched with a current medical student in either the Black and Latinx Student Association (BALSA) or LGBTQMed who will share their experiences navigating medical school.

Apart from the liaison program, NYU participates in the Science Technology Entry Program (STEP), which provides academic guidance to middle and high school students who are underrepresented minorities.[36] With the set programs in place, one would expect to find a significantly larger proportion of Latino medical students in the university.

The Medical School Admission Requirement (MSAR) database compiled extensive data about participants in the medical school; the data range from tuition to student body demographics. Of the admitted medical students in 2021, only 16 out of 108 identified as Latino, despite the much larger Latino population of New York.[37] Furthermore, only 4 percent of the admitted students classify themselves as being from a disadvantaged status.[38] The current efforts to increase medical school diversity are not producing adequate results at NYU. Although the Latino representation in this medical school may be higher than that in others, it does not reflect the number of Latinos in Manhattan.

The Prospective MD Student Liaison Program intervenes at a late stage of the medical school application process. It would be more beneficial for a program to cover the entire application process. The lack of Latino medical students makes it difficult for prospective students to seek advice from Latino students.

Introducing low-income Latino applicants to enrolled Latino medical students would serve as a guiding tool throughout the application process. An early introduction could encourage the applicants to apply and provide a resourceful ally in the application process when, in many circumstances, there would be none. Latino medical students can share their experiences of overcoming cultural and social barriers to enter medical school.

b) The Latino population in Philadelphia is over 250,000, constituting about 15 percent of the 1.6 million inhabitants.[39] According to MSAR, the cohort of students starting at Drexel University College of Medicine, located in Philadelphia, in 2021 was only 7.6 percent Latino.[40] 18 percent of matriculated students identify as having disadvantaged status, while 21 percent identify as coming from a medically underserved community.[41]

Drexel University College of Medicine claims that "Students who attend racially and ethnically diverse medical schools are better prepared to care for patients in a diverse society."[42] They promote diversity with various student organizations within the college, including the following: Student National Medical Association (SNMA), Latino Medical Student Association (LMSA), Drexel Black Doctors Network, LGBT Medical Student Group, and Drexel Mentoring and Pipeline Program (DMAPP).

The Student Center for Diversity and Inclusion of the College of Medicine offers support groups for underrepresented medical students. The support offered at Drexel occurs at the point of matriculation, not for prospective students. The one program that does seem to be a guide for prospective students is the Drexel Pathway to Medical School program. Drexel Pathway to Medical School is a one-year master's program with early assurance into the College of Medicine and may serve as a gateway for prospective Latino Students.[43] The graduate program is tailored for students who are considered medically underserved or socioeconomically disadvantaged and have done well in the traditional pre-medical school coursework. It is a competitive program that receives between 500 and 700 applicants for the 65 available seats.

The assurance of entry into medical school makes the Drexel Pathway to Medical School a beneficial program in aiding Latino representation in medicine. Drexel sets forth minimum requirements for the program that show the school is willing to consider students without the elite scores and grades required of many schools. MCAT scores must be in the 25th percentile or higher, and the overall or science GPA must be at least 2.9.[44] The appealing factor of this program is its mission to attract medically underserved students. This is a tool to increase diversity in medical school. Prospective low-income Latino students can view this as a graduate program tailored to communities like theirs. However, this one-year program is not tuition-free.

It may be tempting to assume that patients prefer doctors with exceptional academic records. There's an argument against admitting individuals with lower test scores into medical schools, rooted in the belief that this approach does not necessarily serve the best interests of health care. The argument asserts that the immense responsibility of practicing medicine should be entrusted to the most qualified candidates. Programs like the Drexel Pathway to Medical School are designed to address the lower academic achievements often seen in underrepresented communities. Their purpose is not to admit underqualified individuals into medical school but to bridge the educational gap, helping these individuals take the necessary steps to become qualified physicians.

c) The University of California San Francisco School of Medicine reports that 23 percent of its first-year class identifies as Latino, while 34 percent consider themselves disadvantaged.[45] The Office of Diversity and Outreach is concerned with increasing the number of matriculants from underserved communities.

UCSF has instilled moral commitments and conducts pipeline and outreach programs to increase the diversity of its medical school student body. The *Differences Matter Initiative* that the university has undertaken is a complex years-long restructuring of the medical school aimed at making the medical system equitable, diverse, and inclusive.[46] The five-phase commitment includes restructuring the leadership of the medical school, establishing anti-oppression and anti-racism competencies, and critically analyzing the role race, ethnicity, gender, and sexual orientation play in medicine. UCSF offers a post-baccalaureate program specifically tailored to disadvantaged and underserved students. The program's curriculum includes MCAT preparation, skills workshops, science courses, and medical school application workshops.[47] The MCAT preparation and medical school application workshops serve as a great tool for prospective Latino applicants.

UCSF seems to do better than most medical schools regarding Latino medical students. San Francisco has a population of 873,965, of which 15.2 percent are Latino.[48] The large population of Latino medical students indicates that the school's efforts to increase diversity are working. The 23 percent Latino matriculating class of 2021 better represents the number of Latinos in the United States, which makes up about a fifth of the population. With this current data, it is important to closely dissect the efforts UCSF has taken to increase diversity in its medical school. Their Differences Matter initiative instills a commitment to diversifying their medical school. As mentioned, the school's leadership has been restructuring to include a diverse administrative body. This allows low-income Latino applicants to relate to the admissions committee reviewing their application. With a hopeful outlook, the high percentage of Latino applicants may reflect comprehension of the application process and the anticipated medical school atmosphere and rigor among Latino applicants and demonstrate that the admissions committee understands the applicants. However, there are still uncertainties about the demographics of the Latino student population in the medical school. Although it is a relatively high percentage, it is necessary to decipher which proportion of those students are low-income Latino Americans. UCSF School of Medicine can serve as a model to uplift the Latino community in a historically unattainable profession.

VII. Proposed Reform for Current Medical School Application

One reform would be toward the reviewing admissions committee, which has the power to change the class composition. By increasing the diversity of the admissions committee itself, schools can give minority applicants a greater opportunity to connect to someone with a similar background through their application. It would address low-income Latino applicants feeling they cannot "get personal" in their application.

These actions are necessary because it is not just to have a representative administration for only a portion of the public. Of the three medical schools examined, the University of California San Francisco has the highest percentage of Latino applicants in their entering class. They express an initiative to increase diversity within their medical school leadership via the Differences Matter initiative. This active role in increasing diversity within the medical school leadership may play a role in UCSF's high percentage of Latino matriculants. That serves as an important step in creating an equitable application process for Latino applicants.

An important consideration is whether the medical school administration at UCSF mirrors the Latino population in the United States. The importance of whether the medical school administration at UCSF mirrors the Latino population in the United States lies in its potential to foster diversity, inclusivity, and cultural competence in medical education, as well as to positively impact the healthcare outcomes and experiences of the Latino community. A diverse administration can serve as role models for students and

aspiring professionals from underrepresented backgrounds. It can inspire individuals who might otherwise feel excluded or underrepresented in their career pursuits, including aspiring Latino medical students. Furthermore, a diverse leadership can help develop curricula, policies, and practices that are culturally sensitive and relevant, which is essential for addressing health disparities and providing equitable healthcare.

It is also important to have transparency so the public knows the number of low-income Latino individuals in medical school. The Latino statistics from the medical school generally include international students. That speaks to diversity but misses the important aspect of uplifting the low-income Latino population of the United States. Passing off wealthy international students from Latin America to claim a culturally diverse class is misleading as it does not reflect income diversity. Doing so gives the incorrect perception that the medical school is accurately representing the Latino population of the United States.

There must be a change in how the application process introduces interviews. It needs to be introduced earlier so the admissions committee can form early, well-rounded inferences about an applicant. The interview allows for personal connections with committee members that otherwise would not be established through the primary application. The current framework has the interviews as one of the last aspects of the application process before admissions decisions are reached. At this point in the application process, many low-income Latinos may have been screened out.

I understand this is not an easy feat to accomplish. This will lead to an increase in interviews to be managed by the admissions committee. The burden can be strategically minimized by first conducting video interviews with applicants the admission committee is interested in moving forward and those that they are unsure about because of a weakness in a certain area of the application. The video interview provides a more formal connection between the applicants and admission committee reviewers. It allows the applicant to provide a narrative through spoken words and can come off as a more intimate window into their characteristics. It would also allow for an opportunity to explain hardships and what is unique. From this larger pool of video-interviewed applicants, the admission committee can narrow down to traditional in-person interviews. A form of these video interviews may be already in place in some medical school application process. I believe making this practice widespread throughout medical schools will provide an opportunity to increase the diversity of medical school students.

There must be an increase in the number of programs dedicated to serving as a gateway to clinical experience for low-income Latino applicants. These programs provide the necessary networking environment needed to get clinical experience. It is important to consider that networking with clinical professionals is an admissions factor that detrimentally affects the low-income Latino population.

One of the organizations that aids underserved communities, not limited to Latinos, in clinical exposure is the Summer Clinical Oncology Research Experience (SCORE) program.[49] The SCORE program, conducted by Memorial Sloan Kettering Cancer Center, provides its participants with mentorship opportunities in medicine and science. In doing so, strong connections are made in clinical environments. Low-income Latinos seek these opportunities as they have limited exposure to such an environment. I argue that it is in the medical school's best interest to develop programs of this nature to construct a more diverse applicant pool.

These programs are in the best interest of medical schools because they are culturing a well-prepared applicant pool. It should not be left to the goodwill of a handful of organizations to cultivate clinically experienced individuals from minority communities. Medical schools have an ethical obligation to produce

well-suited physicians from all backgrounds. Justice is not upheld when low-income Latinos are disproportionally represented in medical schools. Programs tailored for low-income Latinos supplement the networking this population lacks, which is fundamental to obtaining clinical experience. These programs help alleviate the burden of an applicant's low socioeconomic status in attaining clinical exposure.

VIII. Additional Considerations Affecting the Medical School Application Process and Latino Community Health

A commitment to practicing medicine in low-income Latino communities can be established to improve Latino community health.[50] Programs, such as the National Health Service Corps, encourage clinicians to practice in underserved areas by forgiving academic loans for years of work.[51] Increasing the number of clinicians in underserved communities can lead to a positive correlation with better health. It would be ideal to have programs for low-income Latino medical students that incentivize practicing in areas with a high population of underserved Latinos. This would provide the Latino community with physicians of a similar cultural background to attend to them, creating a deeper physician-patient relationship that has been missing in this community.

Outreach for prospective Latino applicants by Latino medical students and physicians could encourage an increased applicant turnout. This effort can guide low-income Latinos who do not see much representation in the medical field. It would serve as a motivating factor and an opportunity to network within the medical field. Since there are few Latino physicians and medical students, a large effort must be made to make their presence known.

IX. Further Investigation Required

It is important to investigate the causes of medical school rejections of low-income Latinos. Understanding this piece of information would provide insight into the specific difficulties this population has with the medical school application. From there, the requirements can be subjected to bioethical analysis to determine whether those unfulfilled requirements serve as undue restrictions.

The aspect of legacy students, children of former alumni, proves to be a difficult subject to find data on and merits further research. Legacy students are often given preferred admission into universities.[52] It is necessary to understand how this affects the medical school admissions process and whether it comes at a cost to students that are not legacy. It does not seem like these preferences are something universities are willing to disclose. The aspect of legacy preferences in admissions decisions could be detrimental to low-income Latino applicants if their parents are not college-educated in the United States, which often is the case.

It would be beneficial to note how many Latinos in medical school are low-income. The MSAR report denotes the number of Latino-identified students per medical school class at an institution and the number of students who identify as coming from low resources. They do not specify which of the Latino students come from low-income families. This information would be useful to decipher how many people from the low-income Latino community are matriculating into medical schools.

CONCLUSION

It is an injustice that low-income Latinos are grossly underrepresented in medical school. It would remain an injustice even if the health of the Latino community in the United States were good. The current operation of medical school admission is based on a guild-like mentality, which perpetuates through

barriers to admissions. It remains an exclusive club with processes that favor the wealthy over those who cannot devote money and time to the prerequisites such as test preparation courses and clinical internships. This has come at the expense of the Latino community in the United States in the form of both fewer Latino doctors and fewer current medical students. It is reasonable to hope that addressing the injustice of the underrepresentation of low-income Latinos in the medical field would improve Latino community health. With such a large demographic, the lack of representation in the medical field is astonishing.

The Latino population faces cultural barriers when seeking healthcare, and the best way to combat that is with a familiar face. An increase in Latino medical students would lead to more physicians that not only can culturally relate to the Latino community, but that are a part of it. This opens the door for a comprehensive understanding between the patient and physician. As described in my thesis, Latino physicians can bridge cultural gaps that have proven detrimental to that patient population. That may help patients make informed decisions, exercising their full autonomy.

The lack of representation of low-income Latinos in medicine is a long-known issue. Here, I have connected how the physician-patient relationship can be positively improved with an increase in low-income Latino physicians through various reforms in the admissions process. My hope is to have analyzed the problem of under-representation in a way that points toward further research and thoughtful reforms that can truly contribute to the process of remedying this issue.

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