We Are Not All the Same: Implications of Heterogeneity Among Latiné/e/x/o/a, Hispanic, and Spanish Origin People

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VISUAL ABSTRACT

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ABSTRACT

There is great variation in the experiences of Latiné/e/x/o/a, Hispanic, and/or Spanish origin (LHS) individuals in the United States, including differences in race, ancestry, colonization histories, and immigration experiences. This essay calls readers to consider the implications of the heterogeneity of lived experiences among LHS populations, including variations in country of origin, immigration histories, time in the United States, languages spoken, and colonization histories on patient care and academia. There is power in unity when advocating for community, social, and political change, especially as it pertains to equity, diversity, and inclusion (EDI; sometimes referred to as DEI) efforts in academic institutions. Yet, there is also a critical need to disaggregate the LHS diaspora and its conceptualization based on differing experiences so that we may improve our understanding of the sociopolitical attributes that impact health. We propose strategies to improve recognition of these differences and their potential health outcomes toward a goal of health equity.

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INTRODUCTION

In this paper, Latiné/e/x/o/a, Hispanic, and/or Spanish origin (LHS) family medicine faculty experts in equity, diversity, and inclusion (EDI; sometimes referred to as DEI) come together to unmask the unique sociopolitical experiences of LHS populations and their impact on clinical care and health outcomes. The varied histories and sociopolitical characteristics, including race and ethnicity, which exist among LHS individuals are important social determinants of health and health inequity. For example, race-based medicine often conflates race, ethnicity, and genetic variations.[1] This can result in dangerous misconceptions and erroneous clinical and research approaches for LHS populations, which then misinform medical education. To address this problem, we specifically call for the recognition of differences, or "unmasking," of the complex layers of difference that exist among LHS individuals for better understanding of the unique sociopolitical risks affecting the optimal care of our patients.

We will use the term LHS to describe a large and heterogenous group of people with Latin American and/or Spanish ancestry now residing in the United States. While imperfect, the term LHS is inclusive and encompasses the heterogeneity of people with Latin American and/or Spanish ancestry now in the United States.[2] This diverse group of people now constitute the largest minoritized population in the United States, representing 19.1% of the population.[3,4]

Two Stories

Historical context is important when considering LHS individuals who have immigrated to the United States. In 1984, a medical student in Argentina (V.M-B.) identified the case of a White-appearing patient with sickle cell disease. She presented the case at a department conference. Enraged, the head physician declared, "Aquí no hay Negros." ["There are no Black people here."]. Yet, 1778 Spanish colonial masters census data estimated a 37% Afro-Argentine population at the time. Today, only 5% of Argentina's population is Black, among the lowest of all Latin American countries.[5] How could this history have impacted the patient and her family? Or the medical student's education? Racialization of the illness—in this case,

attributing an illness only to a specific race without consideration of ancestry or other clinically relevant factors—delayed diagnosis and treatment of a vaso-occlusive crisis, even after the death of 2 siblings with the same condition.

More recently in 2020, an Afro-Latine physician aged 40 years, originally from Colombia, South America, began to experience right breast pain. As recommended, she waited a few months to determine whether the pain was menses-related. It was not. There were no skin changes and no siblings or parents with a history of breast cancer. She had 2 female cousins with previous breast cancer diagnoses, but they were twice removed, and Caribbean, so did not meet criteria for mammogram-based risk assessment per national guidelines (notably, this story began before the release of the 2023 United States Preventive Services Task Force [USPSTF] guidelines calling for mammogram screening starting at age 40 years). Physicians told her it was very unlikely "someone with her background" would have a genetic risk factor for breast cancer. Three months later, she was diagnosed with Stage 3b breast cancer and tested positive for the BRCA-1 gene. Neither her primary care physician nor her geneticist recognized that Colombia is the second most ethnically diverse country in Latin America, resulting in significant genetic heterogeneity. There is evidence of a specific Caribbean mutation for BRCA-1 and also that BRCA-1 mutations are responsible for 80% of breast cancers in Colombians of African descent and of a specific Caribbean mutation for BRCA-1.[6] Not only did this patient's medical team not know the significance of her ethnic background, but they also made erroneous race-based assumptions with nearly fatal consequences.

These stories illustrate the danger of not knowing, understanding, or acknowledging heterogeneity among LHS individuals. The conflation of race, ethnicity, and genetic variations influences consideration of clinical data and clinician decision making for LHS patients. Race and ethnicity can have a biologic impact on epigenetics and health outcomes across generations,[7] but race is often treated strictly as a biologic factor rather than the sociopolitical construct that it is.[8,9] While these stories may seem unfamiliar to non-LHS individuals, based on the lived personal and professional experiences of this author group, such cases are pervasive in patient care, medical education, and research of LHS populations. Although this paper is not exhaustive, we will discuss aspects of LHS heterogeneity often missing in the literature, including nationality, Afro-Latinidad, Indigenous ancestry, migration experiences, and their health implications.

Nationality Narratives Shape Experience and Identity

Identity is not limited to first-hand experiences in a country of origin, but grows from shared regional narratives, as evidenced by 3 of the authors (D.N.C., E.F., J.E.R.) who are of Puerto Rican descent. Due to their birth and upbringing on the US mainland, they have no true "immigration" story. Their experiences with immigration are minimal, shielding them from certain forms of racism imposed by US sociopolitical contexts and structures. Their "nationality" narrative is one of Spanish and US colonization and slavery, like other groups in the Americas, resulting in mixed ancestry of Indigenous, African, and European roots. Though the genocide of most Indigenous populations in the Caribbean occurred 400 years ago, Indigenous legacies are reflected not only in biologic connections, but also in the traditions that define many LHS identities. For those with Puerto Rican roots, it sometimes feels misleading to identify as such. Some have never lived there (eg, D.N.C., E.F., J.E.R.), and so it seems a stretch to call the island anything more than an "ancestral homeland." The authors who identify as Puerto Rican are relatively light-skinned and, with effort, could pass as White in the United States, but phenotype has little to do with their identities. Being born and raised on the US mainland, appearing White at times and not at all White at other times, there is "othering" that occurs because of this oscillation in external perceptions which results in unique and varying perspectives on identity. At times, there is even a sentiment of no true "nationality." This phenomenon is shared by many LHS-identified individuals raised in the United States "Ni de aquí, ni de allá" ["We are not from here or from there"].

Afro-Latiné/e/x/o/a and Indigenous Ancestries Shape Experience and Identity

For most LHS people, African heritage is undeniable given the history of Spanish slave trade during colonization. Afro-LHS individuals are often racialized as Black, regardless of their self-identified race/ethnicity, contributing to their lived experiences in the United States. Given the prevalence of anti-Blackness in the United States, there are significant sociopolitical, economic, and health-related implications to being racialized as Black.[10] There are at least 3 external forces that contribute to isolation in some Afro-LHS individuals in the United States, (including one of the authors [I.M.]): (1) overall anti-Blackness in the United States[11,12]; (2) lighter-skinned LHS individuals may also have anti-Black attitudes that perpetuate the erasure, or removal of, Afro-LHS lived experiences from the comprehensive LHS narrative; and (3) members of US-born Black communities may question and minimize the Black experience and identity of Afro-LHS individuals. The summative experience of racial discrimination and associated stressors has negative health implications on all levels.[13-17] Notably, the 2 stories shared above illustrate the detriments of relying solely or mostly on race when considering clinical diagnoses.

Like anti-Blackness, anti-Indigenous racism is pervasive in the Americas including among US LHS communities.[18] Virtually every Spanish-speaking country in the Americas has attempted or successfully erased Indigenous populations. Yet, the 63 recognized native languages spoken in Mexico illustrate the continued presence of Indigenous traditions in this region of Latin America which represent perseverance despite attempted or successful genocides. In Paraguay, both Spanish

and the Indigenous language Guaraní are the official languages. In the United States, however, LHS Indigenous individuals who do not speak Spanish may have little access to translation services. Unfortunately, they may be mislabeled as Spanish-speaking, and assumed to have similarities to populations that are vastly different socioculturally and genetically.

Migration Pathways Shape Experience and Identity

Migration experiences also contribute to LHS population heterogeneity. Migration trajectories result in diverse experiences of racialized legal status that begin before relocation and continue throughout life in the United States, carrying significant sociopolitical, economic, and health consequences.[19] Diversity of LHS immigration trajectories include timing and reason for immigration to the United States, ranging from those who immigrated at an early age with or without parents, to those who immigrated as young adult asylum seekers; and those immigrated with visas for professional purposes, but whose initial careers and families remain in their countries of birth. The number of generations preceding one's residence in the United States and whether one's parent(s) are foreign-born is also important in understanding LHS experiences.[20]

Immigration to the United States can come with the privilege of existing status (a visa, or Legal Permanent Resident status) or may require refugee status, asylee status, or Entry Without Inspection (EWI). The lived experiences of LHS immigrants in the United States are also shaped by class, including a social class that may be entirely different from the one held in their country of origin. Additionally, for LHS international medical graduates, a medical degree and Educational Commission for Foreign Medical Graduates (ECFMG) certification has been the pass to a J1 visa for residency training in the United States, with an accompanying requirement of returning to their country of origin unless deemed useful to the United States (eg, by working in a health professional shortage area). In contrast, the lived experience of undocumented individuals or those with in-between states, such as Deferred Action for Childhood Arrivals (DACA) status, is interwoven with fear.[21] The constant possibility of deportation or DACA termination, contrast the stability, security, and privilege that accompanies US citizenship.

An important aspect to bring attention to is the societal-level implications of DACA status regarding the health care workforce. Only 6.3% of the physician workforce is LHS,[22,23] despite the growing need for a language- and cultural-concordant workforce for LHS patients. Yet, DACA continues to be a requirement for capacity to train and practice medicine for many in the LHS trainee community. DACA's status remains at stake with serious ramifications if repealed, as an estimated 29,000 health care workers and trainees will be lost from our workforce.[24]

The cumulative impact of prolonged exposure to chronic fear on health must be recognized in clinical care and research. Concomitantly, having an undocumented family member in a household can deter insurance enrollment despite eligibility.[25] In fact, recent analyses by 2 authors (G.P., V.M-B.) demonstrates that among the 11% LHS population in North Carolina, 3 in 4 foreign-born individuals are not naturalized. Furthermore, 44% of all LHS individuals in North Carolina aged 19-64 years are uninsured compared with 16% of Non-Hispanic Black and 11% of Non-Hispanic White individuals in this age group.[26]

Unity and Disaggregation Can and Should Co-Exist

With all our heterogeneity as individuals of LHS descent, we share similarities across language, culture, and stories—our histories are deeply connected. Many of us consider the United States our home, although we are often othered. In our experiences of otherness, however, we find solidarity. This unity is useful as we seek to address the inequities our LHS patients experience, and at times, can amplify our representation in research and in medicine. Yet, aggregation of our stories and our data can mask and even erase, profound inequities.[27] Therefore, recognizing LHS diversity and incorporating such knowledge into practice holds significant potential. Disaggregation is important for us as clinicians, educators, and researchers, and even more so for our patients. Recognizing the implications of our varied histories, cultures, immigration experiences, intergenerational differences, and their impact on health is critical to improving care delivery, medical education, and medical research. As LHS clinician faculty, we assert that we can both unite in our commonalities and intentionally recognize our differences for the betterment of our patients' health.

Strategies for Moving Forward

As we strive for equity for all patients, including those of LHS origin, we offer the following strategies for positive change:

1. First, our medical community must learn of the distinct and important sociopolitical characteristics and histories that exist among LHS populations. These factors are important social drivers of health inequity. To this extent, we must not conflate race and ethnicity.[9] LHS individuals are of different races and backgrounds based on colonization and immigration histories. Although race is not a biologic construct, race does have profound social, economic, political, and health-related implications, depending on how one is categorized by the dominant race. When LHS data are disaggregated by race, country of origin/birth, time in the United States, and immigration status, health inequities are uncovered.[28-30]

2. Policy makers and data set custodians must recognize varied LHS experiences to drive more representative data collection, evaluation, and application. This includes data disaggregation among LHS communities in collection and analysis of health outcomes in public and private settings. Moreover, disaggregation of data for LHS faculty, health care professionals, and students is crucial as we seek to create interventions for the most underrepresented among us.[31]

There is a particular dearth of data disaggregation in this realm as most LHS faculty, students, and other health care professionals are lumped into one group and homogeneity is inaccurately presumed.[31-33] Recognizing geographic and regional differences can help facilitate disaggregation of LHS population data and improve sample sizes. For example, there are higher percentages of Caribbean individuals in the Eastern United States, and more Mexican-origin populations in the West.[34]

3. We advocate for the intentional development and funding of community led LHS research agendas and their dissemination to researchers, clinicians, and learners to improve health equity research, medical education, policy reform, and ultimately, health outcomes. Additionally, we advocate for the use of novel research approaches: application of an intersectional lens, multigenerational analysis, and multi-dimensional modeling.[35,36] We encourage the use of more robust qualitative and mixed methodologies that center culturally grounded health care research. Additionally, we must advocate that policymakers create more diverse representations of the LHS community in institutional and community leadership, EDI efforts, and in multisectoral collaborations that impact health outcomes.

4. Lastly, we acknowledge that disaggregation is not the ultimate answer and can even be harmful. It is important to understand which subgroups comprise the LHS community in any geographical region. In states where there are several LHS population subgroups, it is important to disaggregate data to examine and recognize inequities. In regions in which the majority of the LHS population comprises 1 or 2 subgroups, disaggregating data may be unnecessary. We must hold private and public sector organizations accountable for implementing changes on a reasonable, mutually agreed-upon timeline. Examples of organizations that we actively sustain include (but are not limited to) our academic institutions, public health departments, and professional societies and organizations.

Unmasking is Critical for Equity

LHS communities have unique and varied stories, histories, races, and cultures. We have shared our stories to exemplify the far-reaching nature of our heterogeneity. While there are times in the realm of EDI that we must stand together to ensure our collective voices are heard, we also specifically acknowledge that it is time for the "mask" of aggregation to come off. Because we are not all the same, disaggregation in clinical care, research, and career advancement is also EDI. This discourse is missing in current health equity and systemic racism discussions. It is our very heterogeneity that we call on our colleagues to recognize so that together we can work toward equity for our patients and our own workforce.

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Key words: Latino; Latina; Latinx; Latiné; Hispanic; Spanish; diversity, equity, and inclusion (DEI); EDI; health equity; heterogeneity; disaggregation

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