Practice Experiences With Latino Immigrant Children

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Mark Dal Corso, MD, MPH[1] and Lauren Biagioli, BS[1]

This brief report summarizes some experiences caring for children in a Federally Qualified Health Center in New Orleans who have recently immigrated to the United States from Central America, with some suggestions for patient management in dealing with these unique experiences that may help providers improve the interactions they have with these patients (Table 1). The reader is referred to many reviews of the medical aspects of caring for recent immigrant children, some oriented more at children being adopted by persons living in the United States and others that more generally address health care concerns of recent immigrants.[1] This report will not review the data documenting the projected increases in the number of immigrants from Latin America to the United States and other reasons for increasing our preparedness to deal with these patients as these have been addressed elsewhere.[2-5] Washbrook et al point out that immigrants to the United States often have language and education skills that can put their children at risk for poorer health outcomes. Examples of how this can affect pediatric practice is discussed.[6]

A Desire for Antibiotics, Injections, and Laboratory Tests

Because antibiotics are much more widely used and often available without a prescription in some Latin American countries, parents often believe that an antibiotic is necessary for the treatment of their child. Pfeiffer[7] comments on this aspect of care regarding the belief that antibiotics may treat upper-respiratory infections and the willingness to use antibiotics without consulting a physician. A child <1 year old presented in our clinic with a mild gastroenteritis. The father asked if we could give the child an injection of Kanamycin. Another example of this is the parents' desire to continue the practice of periodic doses of antiparasitic medications—perhaps as often as every 3 months—often seen in Latin American countries. These beliefs that antibiotics are necessary, and more effective if injected, leave many parents disappointed if they are not prescribed. A clinical diagnosis, depending on the history and physical—for example, in the case of gastroenteritis mentioned above—may also cause concern among parents if it is not backed up by a laboratory test. A suggested response to these situations can be the use of a written handout describing the treatment options for upper-respiratory infections and other viral illnesses. Additionally, as practitioners, we often tell parents to return if the child does not improve. We must make accommodations for those parents who would need to pay out-of-pocket if the child is uninsured because this explains why they may more forcefully request treatment at the first visit.

Immunization Issues

Children in developing countries are of course subjected to the immunization schedule prevalent in their home country. Jenista[4] addresses many of the specific issues around administration intervals, vaccines administered at ages younger than those recommended in the United States, and fraudulent or inappropriately stored vaccines. This brief report only addresses the experiences around updating vaccine records based on records brought from Latin America. If a patient immigrates to the United States and brings their immunization card with them, it is relatively easy to create an immunization record for use in the state where they reside. The author resides in Louisiana and uses the Louisiana Immunization Network for Kids Statewide (LINKS) database to create and update patient records. This requires that one carefully discern what immunizations they have previously received (in Spanish terminology) and will usually require one to do an internet search to find the names of combination vaccines used in other countries. Often, newer vaccines were not administered in the home country such as those for varicella, rotavirus, HPV, and hepatitis A. Oral polio vaccine is most often used in Latin America, and of course, many children will have received a BCG at birth. If the person updating the record speaks limited Spanish, then they must become familiar with the dating system used in Latin America,

[1]Tulane University, New Orleans, LA, USA

Corresponding Author:
Mark Dal Corso, School of Public Health and Tropical Medicine, Tulane University, New Orleans, LA, USA.
Email: dalcorso@tulane.edu

Table 1. Summary of Problems and Solutions When Working With Latino Immigrant Children

Common Problems	Possible Solutions
Parental desire for antibiotics and laboratory tests	• Instead of a prescription use, a patient education handout in Spanish to guide a discussion of common illnesses and approaches to their management
Immunization issues	• Preparation of an information sheet for ancillary medical personnel describing the names of vaccine preparations common in Latin America, particularly combination vaccine products • In-service for medical assistants regarding the dating and naming norms used in Latin America • A handout for parents about vaccine catch-up schedules and availability of all CDC Vaccine Information Sheets (VIS) in Spanish
History taking issues, especially extensive problem lists generated during the first visit	• Manage recent or more severe problems during the first visit • Create an action plan with the parent for ongoing health maintenance • Discuss options for payment issues, especially introduction to assistance programs that the family can access
Family and parenting issues	• Attempt to openly discuss the communication problems between adolescents and parents, especially when different rates of enculturation are occurring • Discuss the need to talk privately with the adolescent and discuss medical confidentiality norms in the United States • Ask about mobility, parental occupation, plans to move, and family structure
Newborns and names	• Pursue clarity in the names of parents while explaining the documentation practices of hospitals, insurance companies, schools, and vital records agencies in the United States • Ensure that medical assistants are also culturally competent in this area and willing to discuss uncertainties to create accurate medical records
Adolescent issues and mental health	• Conduct mental health screening for depression, anxiety, PTSD, and other disorders • Advocate for mental health care for both parents and patients, especially when specific diagnoses are made and for parent-child conflict
Cultural and language issues	• Life-long dedication to learning from our patients about their beliefs and worldview while advocating for institutional language competency at all levels of care

Abbreviations: CD, Centers for Disease Control and Prevention; PTSD, posttraumatic stress disorder.

which places the day of the month before the month and year, often causing confusion in the dating of these immunizations.

Many children immigrate without their vaccine record and must follow the catch-up immunization schedule used within their state. These children have often received the first set of catch-up vaccines at an immigration detention center or from another provider. The parents of these children are often under the misconception that their children are up-to-date and that no further immunizations are necessary. These parents require a detailed explanation of catch-up vaccinations. Parents can be encouraged to obtain the immunization records for their children from the previous caretaker in the home country. If a purified protein derivitive (PPD) is placed, it will of course sometimes be read as positive if the child has received a BCG vaccine at birth. Our state uses an interferon-γ release assay for TB infection (T-SPOT) to confirm all positive Tuberculin Skin Tests (TSTs). This requires setting up an appointment with our state TB program clinic and following up with results.

History Taking Issues, Especially During the First Visit

A valuable source of information to assist in evaluating a recently arrived immigrant child is the American Academy of Pediatrics Immigrant Child Health Toolkit.[8] History taking for recent immigrants during the first clinic visit is often more challenging than it might be for other patients. The child will most often be brought in by the biological mother. One will often find during this

first visit that the mother immigrated to the United States in the distant past (perhaps more than a decade), and the child was raised during that time by a family member, usually a maternal or paternal grandparent. This creates a situation where the mother is often giving the patient's past medical history from what she has heard from the caretaker during the years that she was separated from the child. This can lead to a higher level of uncertainty regarding previous diagnoses, previous treatments, and the chronology of events. These uncertainties are often compounded by several issues specific to immigrant health care. First, the parent will often believe that a superior treatment may be available to their child in the United States than the one they received in their home country, so they will often present many symptoms and diagnoses as being current when they actually occurred years in the past. Second, it will be much more difficult, if not impossible, to request medical information from a previous provider. Third, because these patients are most often uninsured and are paying for their clinic visits, the parent will try to fit as many problems as possible into that first visit to avoid follow-ups. We often deal with one or two issues that seem more important or more recent and then suggest a care plan established with the parents for unresolved concerns.

Family and Parenting Issues

For an excellent review of cultural considerations in caring for immigrants, one can refer to the HRSA (Health Resources and Services Administration) document, Quality Health Services for Hispanics: The Cultural Competency Component.[9] As mentioned in the previous section, many of these children will come to the United States after an extended period of living with a grandparent and be quite unfamiliar (and uncomfortable) with their biological parent now caring for them in the United States This is especially true with adolescents. In some cases, the mother and the father may have separated during their time here in the United States, and so when the children come to join the family, they can find that there are multiple households, often in multiple states. With no legal process for determining custody, it can become confusing at times to find the responsible person for the child's care. The author has patients who come to the clinic at different times with a different parent, and there may be claims of child abuse or neglect by the other parent necessitating referral to child protection services. The tenuous legal situation of these children combined with the extremely high mobility of parents makes these cases especially difficult to follow. Parenting issues, especially in adolescents, is further made difficult by the different rates of cultural adaptation in the family members. Parents hold more closely to their traditional values while the patient is often rapidly adapting to both the language and cultural aspects of the United States—especially by their integration into school. Exposure to different mores, including those regarding sexual activity, use of drugs, and alcohol, and family connectedness will widen the normal generational divide seen between parents and adolescents. During the evaluation of adolescents, parents will often be more resistant to allow the physician to talk alone with the patient and manage some clinical issues independently of the parent. These differences in patient management, especially regarding confidentiality, must be discussed openly with both the parent and the patient.

Another parenting issue important in these patients is the extreme mobility often seen in these families. Having immigrated to the United States, they often move for better work opportunities, with the father often moving first and the family following later. Having no house to sell, no retirement benefits to lose, no work-related health insurance to lose, and often no other extended family living close by facilitates hypermobility. These families are not adverse to risk. This mobility is a constant concern when trying to deliver continuity of care. The author had a patient with a life-threatening illness leave town during their workup, had a suicidal adolescent leave the state with her father one night instead of going to the emergency room for admission, and of course has had many patients who did not return for follow-up and whose phone numbers were no longer in service when called.

Newborns and Names

When caring for a newborn it is routine to ask the parents, if available, how many other children they have to assess their experience in child care. With recent immigrant mothers of newborns, it is not at all unusual to find that they may have 2 or 3 older children, often in their teens or early twenties. Often, these children may live back in their home country. These mothers have an understandable degree of uncertainty in caring for their newborns, and it is advisable to spend adequate time discussing child care issues with these mothers, much as would be done with a primipara.

Newborns bring up the issue of patient names, which can be very confusing and cause problems with patient records, immunization records, and billing. In most Latin American countries, a child will usually use 2 last names—their father's last name and their mother's last name. If a middle name is included, the child may have 4 names. A hospital may include both of these last names on the birth certificate (and, thus, on the Medicaid application) or may only include one. The person filling out

records may be uncertain as to which is the last name and may inadvertently skip the paternal last name. If the parents are not legally married and/or do not have a marriage certificate with them, this may become even more confusing to the hospital staff assigning the name. Because most immigrants believe that having a child born in the United States will at some point provide some advantage to their own immigration status, this can become very important to the parents, especially the father, if their last name is not included in the last name of the child. The author has been asked by parents to change the name on the medical record to better reflect what they believe should be the correct naming of the child. We defer this type of change to our state office of vital statistics, which has a mechanism to do this. Medical records and Medicaid billing usually follow the birth certificate spelling of the name. Even when the names are listed correctly on the medical record, medical staff creating a patient record in an electronic state immunization system often err in listing the name, which can cause problems later when searching for a record or when printing a record for use at school.

Adolescent Issues and Mental Health

Caring for a recent immigrant adolescent who has been reintroduced to their parents after several years, in a country which speaks a different language and immediately places them into schools can be a complicated process. Common adolescent issues are exaggerated in recent immigrants as they are introduced in the United States to drug and alcohol access, sexual activity, and school performance issues. Diagnoses of mental health problems such as depression and ADHD (attention-deficit hyperactivity disorder) are compounded by the lack of availability of mental health services in Spanish, especially to those without health insurance or Medicaid. Problems of violence and abuse in their home country or during their travel to the United States are often discovered during those first clinic visits with a pediatrician, and depression screening is an important part of the care of these adolescents.

Consideration of the trauma that these patients may have experienced either in their home country, during travel to the United States, or in detention centers in the United States is an important part of guiding the initial evaluation and follow-up of these patients.[10,11] The added stress of having passed through a detention center and then living in a mixed-status family with the fear of deportation can also add to risk for mental health problems seen in these patients.[12] Providers should ask about the detention experience and recognize that children who come unaccompanied by their parents are often detained in these centers for extended periods. They may receive immunizations and other medications along with mental health diagnoses and treatments before being released from there to the parents. Records from these centers are usually given to the parents who, hopefully, bring them to the first clinic visit.

During ongoing care and follow-up, it is important to consider that the health of many immigrant children deteriorates in the United States because of the lack of health insurance, exposure to fast foods, reductions in physical activity, and other factors.[13]

Cultural and Language Issues

This final topic is perhaps too broad to cover in detail in this brief report, but a few points related to pediatric practice are important. Often the child, especially adolescents, may be more fluent in English than his or her parents and may prefer to speak English. Because providers see the child as the patient, we often adapt to their language desires, which can exclude the parent to a certain degree, necessitating intermittent translation for the parent's sake. Often grandparents are present with the child's parent. Even though the provider may not feel the necessity of involving them in the conversation, the norms of respect in Latino culture necessitate that we do so, especially if we desire their "buy-in" to the interventions we are initiating.

Language issues can become an even more important issue when an on-call provider is taking phone calls from parents. Even a relatively fluent provider may have problems communicating with a person by phone in Spanish. The educational level of some immigrants combined with the limited fluency level of some providers makes phone communication difficult. These patients have probably never had access to a physician on call by phone in their home countries and so are not accustomed to describing a clinical problem briefly and accurately. This may be compounded by their unfamiliarity with a new city that they have immigrated to. Telling a parent to take their child to an emergency room may necessitate giving the exact street address to the patient, spelling out the names of the streets involved, and explaining how to get there. Sharing call or coverage with other providers who do not speak Spanish and having medical students or residents in clinic can also complicate the communication process. In general, one will usually find that persons of Latin descent place much importance on the relationship they have with their provider and prefer to be seen by the same physician as much as possible. It is important to remember that not only the provider but the entire system must be able to communicate and interact

across language barriers and that a culturally competent health care system can improve health outcomes.[14]

In summary, it is important for the provider to be empathetic to the persons he or she is treating. It is probably not possible for those who have lived in the United States their entire lives to understand experiences children have had in their home countries or the risks that parents are willing to take for their children. Persons come to avoid violence and poverty, to look for a better job, and in general, to find a better life. The American Academy of Pediatrics makes many recommendations for policy interventions that pediatricians can be involved in to influence immigrant child health.[5]

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MDC: The conception design, and drafting of the article including topics, content, and literature review. LB: Design, critical revision, and integration of literature review.

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